APPENDIX F
BCBSM Pay for Performance
Collaborative Quality Initiatives[14]

Sponsored by Blue Cross Blue Shield of Michigan and Blue Care Network, Collaborative Quality Initiatives (CQI) bring together Michigan physicians and hospital partners to address some of the most common and costly areas of surgical and medical care. As a result of the collection and analysis of procedural and outcomes data from each hospital, the participants are able to implement changes in practice based on the knowledge acquired from the initiative. These changes in practices lead to increased efficiencies, improved outcomes, including decreased complication and mortality rates, and enhanced value such as improved clinical outcomes and lower costs.

BCBSM and BCN have ten CQI'S that are ongoing in the current experience period and are listed below:

Advanced Cardiac Imaging Consortium (ACIC)

The ACIC project is aimed at improving the quality of care for patients through encouraging the appropriate use of Coronary Computer Tomographic Angiography. The objective of the consortium is to develop and implement a collaborative radiation dose reduction program and evaluate current referral patterns for CCTA, determine the best clinical use of CCTA, influence practice patterns by sharing data on current guidelines and referral patterns and evaluate long-term outcomes of patients undergoing CCTA. Results demonstrated reduced radiation dosage for heart CT angiography by 53.3 percent.

Michigan Bariatric Surgery Collaborative (MBSC)

This partnership with physicians and hospitals is designed to make weight-reducing bariatric surgery safer and potentially less costly across the state.

All Michigan hospitals performing bariatric surgery are invited to share information on procedures and outcomes in a data registry. The data are be used to help determine which practices produce the least risk, fewest complications and the best results while, at the same time, help reduce costs for these increasingly common and expensive procedures. Top-line results showed overall complication rates decreased by 24 percent and visits to emergency rooms following surgery declined 31 percent.

Michigan Hospital Medicine Safety Consortium (HMS)

This initiative, introduced in October 2010, addresses improving the quality of care for hospitalized patients who are at risk for developing blood clots. Participants aim to improve the care of medical patients at risk for hospital-associated blood clots. The objectives of the program are to evaluate and understand current practice of pharmacologic blood clot prevention for high

[14] http://www.bcbsm.com/provider/value_partnerships/cqi/

risk medical patients, implement improvements strategies and evaluate change over time, identify, develop and implement systems-based strategies to improve overall rates of blood clot prevention in defined populations.

BCBSM-Cardiovascular Consortium-Peripheral Vascular Intervention Quality Improvement Initiative

The BMC2-PVI initiative is designed to decrease complications and improve medical therapy for patients with severe peripheral arterial disease who undergo peripheral vascular intervention. Currently, there are 18 Michigan hospitals and 267 physicians participating in the initiative. The objectives of the program are to reduce blood transfusions after percutaneous arterial intervention and increase the use of recommended medical therapy that's been shown to decrease risk of cardiovascular morbidity and mortality especially for at-risk populations. Results of the initiative have been positive with a 7.2 percent decrease in post-PVI blood transfusions and significant improvement in the use of essential medical therapies, including antiplatelet and statin medications among physicians at participating sites.

BCBSM Cardiovascular Consortium-Percutaneous Coronary Intervention

This BMC2-PCI initiative aims to improve the care of patients with coronary disease who undergo angioplasty by reducing complications such as kidney damage, the need for blood transfusions and the need for open heart surgery. Furthermore, participating hospitals learn from one another by sharing best practices based on evidence-based medicine to improve quality and outcomes. The objectives of the initiative are to reduce vascular access complications, reduce the post PCI transfusion rate, reduce the rate of contrast induced nephropathy, acute kidney failure that can develop as a result of the dyes used in procedures and reduce nephropathy requiring dialysis. Results from the initiative showed:

- ♦ 30 percent reduction in hospital deaths
- ♦ 38 percent reduction in contrast-induced nephropathy
- ♦ 31 percent reduction in blood transfusions after angioplasty
- ♦ 19 percent in vascular complications
- ♦ 49 percent reduction in emergency revascularization (repeating original procedure)
- ♦ 28 percent reduction in gastrointestinal bleeding

The estimated savings from this initiative is $15.2 million annually in statewide health care costs.

Michigan Trauma Quality Improvement Program

The Michigan Trauma Quality Improvement Program aims to address inconsistencies and variations in patient outcomes related to trauma-based care. The goal of MTQIP is to create a statewide quality improvement infrastructure for trauma care that endeavors to improve the quality of care for trauma patients and reduce the costs of this care in Michigan. To accomplish

this goal, it is imperative to support the ability of trauma centers to voluntarily collect and disseminate data on individual center performances in a non-punitive manner. This structure allows for continuous quality improvement and monitoring of patient outcomes, thereby advancing the trauma system.

The objectives of the initiative are:

- ♦ Bring eight more Michigan trauma centers on board by January 2012
- ♦ Utilize the existing trauma registry system at each participating hospital to build a sustainable and cost efficient system to track patient outcomes with data standardization
- ♦ Enroll each participating hospital in the American College of Surgeons Trauma Quality Improvement Program
- ♦ Collaborate with the trauma medical directors and care providers at each MTQIP hospital in a process to identify and promulgate "best practices", based on learning from the MTQIP and ASC-TQIP data registry
- ♦ Create a system of providers, consumers and payers that employs comparative effectiveness to improve care for trauma patients

Michigan Surgical Quality Collaborative

Sixteen of the largest hospitals in Michigan are participating in an initiative that evaluates the results of general and vascular surgery procedures performed in their institutions. This collaboration is an effort between the American College of Surgeons and a BCBSM to evaluate and improve the quality of surgical care while ultimately reducing health care delivery costs.

Data on the outcome of surgeries is being submitted to the American College of Surgeons' National Surgery Quality Improvement Program. The goal is to use the data to reduce infection, illness or death associated with selected surgical procedures.

Perioperative Outcomes Initiative (POI)

The Perioperative Outcomes Initiative began in 2010 and aims to improve processes in the operating room that contribute to patient outcomes. This unique initiative is aligned with the Michigan Surgical Quality Collaborative, evaluating the perioperative processes of care and outcomes of patients included in MSQC (Michigan Surgical Quality Collaboration) data collection efforts. POI focuses on the perioperative processes and staffing arrangements during MSQC-reported surgical procedures and outcomes. POI findings are used to reduce complications or other adverse events.

This initiative collects perioperative process data such as intraoperative times (throughput), skin preparation and patient positioning, count discrepancy (count information only), staffing arrangements, preoperative assessments and time-outs, and high-level cost information. Data components from both MSQC and POI are then used to evaluate the impact of process on surgical patient outcomes and hospital interests.

- ♦ Determine optimum operating room staffing associated with timeliness and proficiency of the perioperative process.
- ♦ Examine the relationship between skin preparation agents and patient outcomes.

- ♦ Evaluate the relationship between OR staffing, perioperative processes and patient outcomes.
- ♦ Evaluate the impact of patient characteristics, OR staffing and perioperative processes on patient outcomes
- ♦ Conduct cost-effectiveness analysis of current perioperative processes and patient outcomes.
- ♦ Share thoughts and data on improving perioperative care and outcomes.
- ♦ Understand and optimize perioperative processes contributing to patient outcomes and hospital performance.

Michigan Breast Oncology Quality Initiative

In 2006 BCBSM is expanding a pilot program to improve the quality of care for the more than 7,000 Michigan women diagnosed with breast cancer each year.

The program expansion will increase the number of Michigan hospitals participating in the initiative. Working with researchers at the University of Michigan Health System, the Michigan Blues invited five new hospitals to participate in 2006. That number grew to 17 in 2007.

The initiative is contributing comprehensive data on diagnostic testing, chemotherapy, radiation therapy and surgery to a registry established by the National Comprehensive Cancer Network. It will help physicians learn what works best in breast cancer treatment.

Thoracic and Cardiac Surgery Collaborative Quality Initiative

This project aims to reduce the risk of complications and improve treatment methods before and after cardiac surgery for thousands of Michigan patients. This collaboration with the Michigan Society of Thoracic and Cardiovascular Surgeons will:

- ♦ Enable greater in-depth analysis of patient data
- ♦ Help coordinate best practices among surgeons in all 31 hospitals in Michigan that offer cardiac surgery
- ♦ Engage surgeons in an effort to delve more deeply than ever before into cardiac surgery outcomes and to take what is learned and apply it to better patient care statewide

The project builds upon data already compiled in the Society of Thoracic Surgeon national database. There are about 20,000 adult cardiac operations in Michigan annually.

APPENDIX G

Participating Hospital Agreement (PHA) Committees
Major Discussion Topics
2010

Committee Name	2010 Meetings	Topics Discussed
PHA Advisory Committee	3	▪ Michigan Market Place ▪ 2010 Cohen Model updated for 2004-2010 Market changes ▪ BCSM communication to hospitals on Cohen recommendations ▪ Pay-for-Performance Update ▪ Trend results and perspectives ▪ BCBSM Urgent Care Center Contracting & Policy Update ▪ 2011 Hospital Update Factors ▪ Medicare Advantage Update ▪ Hospital Insights Update ▪ Member Communication on cost Sharing Responsibilies ▪ Professional fee schedule change implications to hospitals
Staff Liaison Group	5	▪ Hospital Insights report ▪ Pay-for-Performance ▪ Outlier reimbursement policies ▪ PHA contract language ▪ PHA reimbursement methodology ▪ ICD 10 Implementation-diagnosis reporting at time of discharge ▪ High Deductible Health Plans implications on bad debt ▪ Keystone and BCBSM Collaborative Quality Initiatives ▪ Urgent care provider class plan ▪ Physical therapy program update
Benefit Administration Committee	7	▪ Future benefit designs and product offerings ▪ BlueCard ▪ Medicare recoveries ▪ Medicare Advantage Behavioral Health program ▪ State wide forum ▪ ICD 10 ▪ Provider Inquiry hours of operation ▪ Michigan Operating system status ▪ Medicare Advantage program status ▪ Payment Assurance Initiatives ▪ Provider Communication Initiatives ▪ EDI 5010 Update
Utilization	4	▪ Care Transition

Management and Quality Assessment Committee		▪ **Diagnosis Related Grouping letters to American Hospital Association Central Office on Coding responses** ▪ **BCBSM Holiday hours case management department** ▪ **Hospital contingent question regarding readmission audits combined with DRG audits** ▪ **New Medicare PPO Program** ▪ **Presentation on Hospital Collaborative Quality Initiatives process** ▪ **Conference call with HealthDataInsights Medicare audits** ▪ **Update on pay-for-performance program: 2009 results and looking ahead to 2011** ▪ **Case management-update** ▪ **HealthDataInsights Audits-Update** ▪ **InterRater Reliability Suite and InterQual Learning Source-McKesson Demo** ▪ **Precertification Services Department-update** ▪ **Case Management Holiday Coverage-Eliminated** ▪ **Executive Health Resources pilot-Update** ▪ **Pay for Performance 2011 incentive program-QA portion** ▪ **Precertification Update-new director & new business (Medicare PPO)** ▪ **Revised BCBSM Audit process-Medical Consultant referrals sent for complicated cases only**
Payment Practices Committee	**9**	▪ **BCBSM Front sheets** ▪ **United Food Works Union claim payment** ▪ **Outpatient surgery pricing and surgery rate adjustments** ▪ **Radiology Prices** ▪ **Hospital-owned Urgent Care Centers** ▪ **Grouper 27 and 28** ▪ **BCBSM copays and deductibles and the Increase in hospitals bad debt** ▪ **Charge-based audits and the hospital attestations** ▪ **Manual vouchers** ▪ **Chemotherapy billing and payment charge** ▪ **Cardiac Inpatient procedures moving to the outpatient setting** ▪ **Market-based pricing and outliers** ▪ **Patient-pay discounts** ▪ **Office-based surgeries** ▪ **Outlier situations in office-based surgeries performed in a hospital** ▪ **Outpatient emergency room surgery** ▪**Guidance to hospitals for patient cost-sharing payments** ▪ **Interqual® reimbursement changes for cardiac conditions from DRG methodology to an outpatient methodology**

Participation Agreements (Attached)

Participating Hospital Agreement

Participating Hospital Agreement – 2009Incentive Program

Participating Hospital Agreement – 2010Incentive Program

09-196

Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Office of the General Counsel
Regulatory Affairs Department
600 Lafayette East, Mail Code 1905
Detroit, MI 48226

June 30, 2009

Susan M. Scarane
Departmental Specialist
Health Plans Division
Office of Financial and Insurance Services
611 West Ottawa Street
Lansing, Michigan 48933

Re: Hospital Provider Class Plan

Dear Ms. Scarane:

Enclosed for filing are Blue Cross Blue Shield of Michigan's Hospital Provider Class Plan and Participating Hospital Agreement. The agreement has been revised to reflect changes to BCBSM's Hospital Pay-for-Performance Program. Exhibit B to the agreement has been redacted according to your direction.

The revisions were approved by BCBSM's Board of Directors on April 29, 2009, after BCBSM obtained input from hospitals and subscribers. The revisions will take effect July 1, 2009.

If you have any questions about this filing, please contact me.

Sincerely,

Lisa Varnier
Assistant General Counsel

Enclosures

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Hospital Provider Class Plan

Table of Contents

Provider Class

A provider class includes health care facilities or health care professionals who have a contract or reimbursement arrangement with BCBSM to render services to BCBSM's members. Qualification standards and the services for which reimbursement is made may differ for the types of providers within a provider class.

Definition

This plan includes all short-term general acute care hospitals, short-term acute psychiatric care hospitals, and intensive rehabilitation programs. Hospitals provide inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons requiring the daily direction or supervision of a physician.

Scope of Services

The scope of the hospital's licensure covers a variety of inpatient acute and outpatient services. Hospital services range from in-hospital physician care, general nursing care, overnight stay, surgery including all related surgical services, obstetric, rehabilitation, anesthesia, lab, x-rays, equipment supplies, and drugs.

PA 350 Goals and Objectives

Provider class plans are developed and maintained pursuant to section 504 of PA 350, which requires BCBSM to provide subscribers reasonable cost, access to, and quality of health care services in accordance with the following goals and objectives.

Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." The goal is derived through the following formula:

$$\left(\frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

Where "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross domestic product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where "REG" means the arithmetic average of the percentage changes in the per capita gross domestic product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

Objectives

- Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions
- Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participating agreement

Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

Objectives

- Provide direct reimbursement to participating providers that render medically necessary, high-quality services to BCBSM members
- Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM's record keeping requirements and the participating agreement and its administration
- Maintain and periodically update a printed or Web site directory of participating providers

Quality of Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

Objectives

- Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards
- Obtain continuous input from hospital through the Contract Administration Process
- Meet with provider organizations such as Michigan Health and Hospital Association to discuss issues of interest and concern
- Maintain and update, as necessary, an appeals process that allows participating providers to appeal reimbursement policies disputes or disputes regarding utilization review audits

BCBSM Policies and Programs

BCBSM maintains a comprehensive set of policies and programs that affect its relationship with health care providers. These policies and programs are designed to help BCBSM meet the PA 350 goals and objectives by limiting cost, maintaining accessibility, and ensuring quality of health care services to its members. To that extent, the following policies and programs may, individually or in combination, affect achievement of one or more of the PA 350 goals. BCBSM annually reports its performance against the goals and objectives for each provider class plan.

Provider Participation

Providers may formally participate with BCBSM or, with respect to some provider classes, providers may participate on a per-claim basis. To formally participate, providers must sign a participation agreement with BCBSM that applies to all covered services the provider renders to BCBSM members. To participate on a per-claim basis, providers must indicate on the claim form that they are participating for the services reported.

Participation Policy

Participation for hospitals is on a formal basis only which means there is no "per-claim" participation. Hospital services rendered by a nonparticipating hospital are for the most part, not reimbursed. In order to participate, providers must meet all of BCBSM's qualification standards.

Qualification Standards

All hospitals may apply to participate with BCBSM. Standards for formal participation include, but are not limited to the items listed below. Hospitals' credentials are periodically reviewed to ensure participation requirements are maintained.

Participating hospitals must meet the following qualifications:

- Michigan licensure as an acute hospital and/or as a psychiatric care hospital or unit
- Medicare certification as a hospital
- Accreditation from one of the following organizations:[1]
  - The Joint Commission on Accreditation of HealthCare Organization (JCAHO)
  - The American Osteopathic Association
  - The Commission on Accreditation of Rehabilitation Facilities

[1] This requirement may be waived if the hospital is located in a rural census category which is further explained in Exhibit A of the attached Participating Hospital Agreement.

- An accreditation organization approved through the Contract Administration Process defined in the Participating Hospital Agreement

- Compliance with applicable Certificate of Need requirements of the Michigan Public Health Code
- Written policies and procedures that meet generally accepted standards for hospital services to assure the quality of patient care and demonstrate compliance with such policies and procedures
- Compliance with generally accepted accounting principles and practices
- Governing board that is legally responsible for the total operation of the facility, and for ensuring that quality medical care is provided in a safe environment. The governing board, or as an alternative, a community advisory board responsible to the governing board, shall include persons representative of a cross section of the community who are interested in the welfare and proper functioning of the hospital as a community facility.
- Absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review, and absence of fraud or illegal activities

Termination of Contract

The participation agreement may be terminated immediately by BCBSM if the provider fails to meet any qualification standard. It can be terminated by either party, with or without cause, upon 120 days written notice to the other party. Other stipulations for terminating the participation agreement are outlined in the Participation Hospital Agreement.

Provider Programs

BCBSM strives to ensure that members receive appropriate and quality care through a combination of provider communications, education, and quality assurance programs.

Utilization Management Initiatives

BCBSM works to ensure that only medically necessary services are delivered to members through utilization management and quality assessment programs. Details of these programs can be found in Exhibit C of the Participating Hospital Agreement.

Communications and Education

BCBSM provides the following resources to communicate with and educate hospital providers:

- The Participating Hospital Agreement Advisory Committee is committed to providing support to the hospital community. The committee meets on an ongoing basis to offer advice and consultation on topics of interest and concern.

- *The Record, Hospital Update* and *Physician Update*, are BCBSM publications that communicate current information regarding billing guidelines, policy changes, clinical news and other administrative issues.
- BCBSM's Web site and online manual provide information on how to do business with BCBSM including billing, benefits, provider appeals processes, managed care, BCBSM's record keeping requirements, the Participating Hospital Agreement, and its administration. BCBSM maintains and updates the Web site and manual as necessary.
- A provider directory on the BCBSM Web site which includes a current list of participating hospital providers
- Provider consulting services to offer assistance to facility staff
- Continuing medical education seminars
- The liaison process such as the Contract Administration Process though which hospitals provide input and recommendations to BCBSM regarding its programs and polices.

Performance Monitoring

- Hospital providers are surveyed regularly to ensure that qualification standards are maintained and up-to-date.
- Suspected fraudulent activity, reported to BCBSM by providers, subscribers, and BCBSM staff, is referred to Corporate Financial Investigations for further investigation.
- Several types of audits are performed that work to ensure that providers rendered services appropriately and within the scope of members' benefits.

Appeals Process

BCBSM's appeals process allows hospitals the right to appeal reimbursement policies or adverse determinations of a utilization review audit. The process is described in Exhibit D of the Participating Hospital Agreement.

Reimbursement Policies

BCBSM reimburses participating hospitals for covered services deemed medically necessary by BCBSM. Payment is limited to the lesser of the facility's charge or BCBSM's reimbursement level.

Covered Services

BCBSM reimburses only for covered services when provided by a participating hospital in accordance with member certificates.* Services provided at a hospital include but are not limited to:

- Room and board
- Surgery
- Maternity care and delivery
- Newborn care
- Emergency treatment
- Dialysis
- Physical therapy
- Chemotherapy
- Pathology and laboratory
- Radiology – diagnostic
- Observation bed
- Medical supplies

Reimbursement Methods

Reimbursement methods are based on hospitals' Peer Group designation. Specifics of the reimbursement structure can be found in Exhibit B of the attached Participating Hospital Agreement.

Peer Groups 1-4 Inpatient and Outpatient Services

Peer Groups 1 through 4 include larger and medium sized acute care general hospitals.

Inpatient services and outpatient surgery, laboratory, radiology, physical therapy, occupational therapy and speech therapy services are reimbursed on a prospective price basis.

Inpatient prices are determined using Medicare's diagnostic related groupings (DRGs), plus a hospital specific amount for capital, graduate medical education, uncompensated care and margin. Additional amounts are reimbursed for qualified catastrophic cases.

Prices for outpatient surgery, laboratory, and radiology services are based on freestanding (facility and professional) provider levels. Prices for physical therapy, occupational therapy and speech therapy services are based on freestanding provider levels, plus a hospital specific amount for uncompensated care and margin. Freestanding provider levels are based on community

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* Emergency services may also be covered by an accredited nonparticipating hospital.

pricing which is founded on the premise that payment for services provided in a hospital or non-hospital setting should be the same.

Hospitals have the opportunity to earn additional amounts on both their inpatient and outpatient payments under a Pay-for-Performance program.

Inpatient prices are updated annually using a formula that is based on the National Hospital Input Price Index (NHIPI). BCBSM does not guarantee that the annual updates will result in increased reimbursement. Hospitals' reimbursement and cost levels will be assessed every three years to determine whether there is a need for pricing adjustments.

Prices for outpatient laboratory, radiology, physical therapy, occupational therapy, speech therapy, and office-based surgery services are updated annually using the professional physician fee updates which is based on the Centers for Medicare and Medicaid Services' Resource Based Relative Value Scale system and a BCBSM conversion factor. BCBSM does not guarantee that the annual updates will result in increased reimbursement.

Other outpatient services may be cost-based until transitioned to community pricing. Outpatient cost-based services that are not routinely available through community providers will be transitioned to fixed statewide base prices using detailed claims information reported by hospitals in accordance with guidelines established by BCBSM.

Peer Group 5 Inpatient and Outpatient Services

Peer Group 5 consists of small rural hospitals that are reimbursed a percent of charges for both inpatient and outpatient services, not to exceed 100 percent of their covered charges. The reimbursement for Peer Group 5 is hospital-specific. Hospitals must attest that their rates are at least as favorable as those for other non-governmental commercial insurers.

Hospitals will participate in a Pay-for-Performance program that will put a portion of the hospital reimbursement at risk.

The reimbursement levels for inpatient and outpatient services are updated annually using the formula that is used by Peer Groups 1 through 4.

Peer Groups 6-7 Inpatient and Outpatient Services

Peer Groups 6 and 7 consist of psychiatric and rehabilitation hospitals and Medicare-exempt psychiatric and rehabilitation units of acute care hospitals.

Inpatient services are reimbursed based on the lesser of hospital's covered charge or BCBSM's per diem level. Annual updates are determined using the same update factor as Peer Groups 1 - 4. BCBSM does not guarantee that the annual updates will result in increased reimbursement.

Outpatient services are reimbursed the same as Peer Groups 1 – 4.

Non-Acute Services

Other hospital-based non-acute services that can be provided under another provider class plan such as, but not limited to, residential substance abuse, home health care agencies, and skilled nursing facilities will be reimbursed using a hospital-specific cost-to-charge ratio set at a level not to exceed 1.0.

BCBSM may require that these services be considered "freestanding" and that they be reimbursed under a separate agreement. In such cases, the hospital will be granted participation status as a freestanding entity and will be given a reasonable amount of time to comply with such standards.

Alternative Reimbursement Arrangement

BCBSM may consider alternative reimbursement methodologies such as "bundled" or "fixed" price arrangements covering all services per episode of care, where the reimbursement methodologies in this plan are not appropriate for payment of certain services, such as bone marrow transplants. All such alternative reimbursement methodologies will be determined through the Contract Administration Process.

Hold Harmless Provisions

Participating hospitals agree to accept BCBSM's payment as payment in full for covered services. Member copayments or deductibles are subtracted from BCBSM's payment before the provider is reimbursed and are the member's responsibility. Participating hospitals must hold members harmless from the following:

- Balance billing for covered services
- Liability for services that are not covered because they are not medically necessary or are experimental, unless the member agrees in writing to pay for the services before they are provided
- Liability for covered services provided but not billed to BCBSM within a prescribed time frame

Participating Hospital Agreement

The Participating Hospital Agreement is attached.

This Agreement is proprietary and confidential. Exhibit B of this Agreement can be released to Hospital's agents, contractors or consultants only if these parties sign a statement agreeing not to disclose the Agreement to third parties. Hospital cannot disclose Exhibit B to any other third parties without the prior written consent of BCBSM.

Blue Cross Blue Shield of Michigan

SECOND AMENDED AND RESTATED

PARTICIPATING HOSPITAL AGREEMENT

Revised – July 1, 2009

This Agreement is proprietary and confidential. Exhibit B of this Agreement can be released to Hospital's agents, contractors or consultants only if these parties sign a statement agreeing not to disclose the Agreement to third parties. Hospital cannot disclose Exhibit B to any other third parties without the prior written consent of BCBSM.

Master Index

This Agreement is proprietary and confidential. Exhibit B of this Agreement can be released to Hospital's agents, contractors or consultants only if these parties sign a statement agreeing not to disclose the Agreement to third parties. Hospital cannot disclose Exhibit B to any other third parties without the prior written consent of BCBSM.

This Agreement is proprietary and confidential. Exhibit B of this Agreement can be released to Hospital's agents, contractors or consultants only if these parties sign a statement agreeing not to disclose the Agreement to third parties. Hospital cannot disclose Exhibit B to any other third parties without the prior written consent of BCBSM.

Second Amended and Restated Participating Hospital Agreement

This Second Amended and Restated Agreement, by and between **Blue Cross Blue Shield of Michigan,** a Michigan nonprofit health care corporation, incorporated pursuant to Michigan Public Act 350 of 1980 as amended (hereinafter referred to as "BCBSM") and **Hospital,** whose tax name and site address is listed on the accompanying Signature Document (hereinafter referred to as "Hospital"), collectively known as the "Parties", **is effective on the later of January 1, 2009 or the effective date indicated on the attached Signature Document.**

PREAMBLE

WHEREAS, BCBSM and Hospital have a mutual concern for high quality of care and recognize as a mutual objective the delivery of services by Hospital, to persons entitled to such services as defined herein, and reimbursement therefore by BCBSM, in a manner that promotes the continuation and improvement of an efficient, effective and consumer responsive health care delivery system; and,

WHEREAS, to achieve this mutual objective, the Parties enter into this Agreement with the following understanding of principles:

A. That each of the Parties has the legal authority to enter into this Agreement and that any other agreements by either Party with any other person or entity will in no way affect the rights or obligations embodied in this Agreement except as may be expressly provided in this Agreement;

B. That BCBSM accepts financial responsibility for the provision of Covered Services to its Members by Hospital and Hospital accepts responsibility for providing such services within the limitation of Hospital's scope of services, looking only to BCBSM for reimbursement, except as otherwise provided in this Agreement;

C. That each of the Parties is committed to the delivery of health care services in an efficient and effective manner, recognizing the need to control and contain cost, and recognizing Hospital's obligation to maintain and improve hospital care;

D. That each of the Parties recognizes that Hospital's governing body has ultimate authority and responsibility for Hospital's operation and a concurrent responsibility to the public in the delivery of health care;

E. That each of the Parties acknowledges its responsibility to the public it serves and its duty to exercise its rights and obligations under this Agreement in accordance with that responsibility; and

F. That BCBSM's social mission requires it to deliver health care services at a fair and reasonable price to all people of the state of Michigan who apply for coverage, and as a result, BCBSM's payment rates should be at least as favorable as those of commercial HMO and PPO payers.

NOW, THEREFORE in consideration of the mutual promises and covenants herein contained, the Parties agree as follows:

Article I
Definitions

1. Audits - the audits set forth in this Agreement and in the Reimbursement Policies.

2. Certificate - benefit plan descriptions under the sponsorship of BCBSM, or certificates and riders issued by BCBSM, or under its sponsorship, or benefits provided pursuant to contracts issued by other Blue Cross or Blue Shield Plans, administered through reciprocity of benefit agreements or other Inter-Plan Arrangements. "Certificate" does not include benefits provided pursuant to automobile no fault or worker's compensation insurance coverage.

   For purposes of this definition, "sponsorship" includes:

   a. Self-funded administrative service accounts of BCBSM for which BCBSM (i) assumes the risk of reimbursing Hospital for Covered Services in the event the payer becomes insolvent and (ii) provides one or more of the following administrative services: utilization management, quality assessments, reviews, audits, claims processing systems or a cash flow methodology.

   b. Self-funded administrative service accounts for which another Blue Cross or Blue Shield Plan is Control Plan and BCBSM is a participating plan and for which BCBSM or the Control Plan assumes the risk of reimbursing Hospital for Covered Services in the event the payer becomes insolvent.

   For purposes of this definition, "sponsorship" does not include health maintenance organizations ("HMO"), preferred provider organizations/point of service ("PPO/POS") benefit designs offered by BCBSM or its subsidiaries, or by other BCBS Plans or their subsidiaries.

3. Clean Claim - a claim submitted in the correct electronic format or on the correct claim form that includes all of the following information:

   a. The name of the Hospital and appropriate provider number;

   b. The name of the Member and the contract number;

   c. Date and location of service;

   d. Description of Covered Services rendered;

e. If requested, substantiation of medical necessity and appropriateness of the care or service provided; and

f. Any additional documentation that may be reasonably requested by BCBSM.

4. Contract Administration Process ("CAP") - the process set forth in Article IV, Sections 1 through 11 of this Agreement.

5. Covered Services - those hospital services, treatments or supplies which are listed or provided for as being covered in Certificates.

6. Customer-Specific Programs - those programs applicable to one or a limited number of BCBSM customers.

7. Experimental Services - those services excluded from payment under BCBSM's Certificates.

8. Medical Necessity or Medically Necessary - a determination that a Covered Service meets all of the following conditions: (i) it is rendered for the treatment, diagnosis or symptoms of an injury, condition or disease; (ii) the care, treatment or supply is appropriate given the symptoms, and is consistent with the diagnosis. "Appropriate" means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment. For inpatient hospital stays, this means that acute care as an inpatient is necessary due to the kind of service the Member requires and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting; (iii) it is not mainly for the convenience of the Member or of the Member's health care provider; (iv) it is not treatment that is generally regarded as experimental by BCBSM, except as otherwise provided in a Certificate and (v) it is not determined to be medically inappropriate by the Utilization, Quality and Health Management Programs.

9. Member - a person entitled to receive Covered Services pursuant to a Certificate.

10. Non-Covered Services - those hospital services, treatments or supplies which are not Covered Services.

11. Non-Reimbursable Covered Services - those Covered Services for which BCBSM will not make payment because the Covered Services are: (i) not Medically Necessary as determined through Utilization, Quality and Health Management Programs, except for those situations referenced in Article III, Section 8; (ii) provided in certain facilities other than those approved by BCBSM.

12. Overpayment - any payment in excess of the amount to which Hospital is entitled under this Agreement.

13. Participating Hospital - any hospital having a contract with BCBSM that is substantially similar to this Agreement.

14. Peer Group - a grouping of hospitals that share similar characteristics such as bed capacity, location, graduate teaching characteristics and specialty type as provided in the Reimbursement Policies.

15. Precertification - a review of a patient's signs, symptoms and proposed treatment to determine whether they meet BCBSM criteria for clinical appropriateness and/or level of care.

16. Prenotification - a process established by BCBSM under which Hospital will report to BCBSM certain information regarding the patient and proposed services.

17. Qualification Standards - those criteria which are used to determine Hospital's eligibility to become or remain a Participating Hospital as set forth in Exhibit A, attached hereto and incorporated herein.

18. Recertification - a prospective review to determine whether admissions continue to be appropriate for the inpatient setting.

19. Reimbursement Policies - the policies which determine the amount of payment due Hospital by BCBSM for Covered Services, as set forth in this Agreement, Exhibit B, attached hereto and incorporated herein, and in the Provider Reimbursement Manual and additional BCBSM published guidelines and criteria.

20. Reviews - the medical and billing reviews set forth in this Agreement and in the Utilization, Quality and Health Management Programs.

21. Non-Network Hospital - any Participating Hospital that has not signed a TRUST Participating Hospital Agreement or other BCBSM hospital network agreements.

22. Underpayment - any payment less than the amount to which Hospital is entitled under this Agreement.

23. Utilization, Quality and Health Management Programs - the Utilization, Quality and Health Management Programs set forth in Exhibit C, and in BCBSM published guidelines, criteria and administrative manuals.

Article II
Hospital Responsibilities

1. General Responsibility of Hospital to Members. Hospital will provide Covered Services to Members which are ordered by a licensed physician or other health care professional in the same manner and quality within the same time frames as those services provided to all other Hospital patients. Hospital shall not be required to provide any Covered Services that it does not customarily provide to others. Hospital will not deny admission or fail to provide Covered Services to any Member by virtue of the Member's BCBS coverage or discriminate against a Member because of his or her status as a Member.

2. Limited Responsibility of a Non-Network Hospital. A Non-Network Hospital, within the limitations of its scope of services, shall provide services to Members in exchange for payment by BCBSM as follows:

   a. For Members that utilize the TRUST hospital network or another hospital network open to all hospitals throughout the State that meet the applicable network qualification standards, BCBSM shall pay Hospital the lower of

(i) charges for Covered Services or (ii) Hospital's applicable rate under the PHA.

b. For Members in PPO/POS benefit designs that utilize PPO/POS hospital networks not open to all qualified hospitals throughout the State or PPO/POS hospital networks for one or a limited number of BCBSM customers, BCBSM shall pay Hospital the lower of (i) charges for Covered Services; or (ii) 115% of the Hospital's applicable rate under the PHA.

3. Hospital Qualifications and Covered Services within Scope of License. Hospital shall have and maintain all the Qualification Standards in Exhibit A and shall comply with BCBSM's recredentialing requirements.

Only those Covered Services provided within the scope of Hospital's license shall be governed by the terms and conditions of this Agreement. Covered Services that are provided outside of the scope of Hospital's license are outside of the scope of this Agreement and shall be subject to a separate agreement with BCBSM pursuant to BCBSM's applicable freestanding facility programs.

4. Scope of Responsibility. The terms of any participating hospital agreement in effect between BCBSM and Hospital on the date a Member's inpatient admission or outpatient service occurs shall govern Hospital's obligations to provide Covered Services to Members. Terms of any participating hospital agreement in effect at the time of admission shall govern for the balance of an inpatient admission.

5. Eligibility, Coverage and Benefit Verification; Prenotification. Hospital shall verify current status of Member eligibility, coverage and benefits for all inpatient admissions for Covered Services and for certain outpatient Covered Services as may be reasonably identified by BCBSM at the time of admission. If Hospital verifies eligibility but BCBSM later determines that the individual was not eligible for coverage, Hospital may directly bill the member for such services. Hospital shall provide Prenotification when required by BCBSM and such other information as BCBSM may reasonably request to help manage patient care.

6. BCBSM Payment. Hospital shall look only to BCBSM for reimbursement for Covered Services in accordance with the Reimbursement Policies, except as otherwise provided in this Agreement.

7. Hold Harmless. Hospital shall not bill or collect from a Member for Covered Services or Non-Reimbursable Covered Services, except that Hospital may bill or collect from a Member for any one or more of the following:

a. Amounts attributable to Non-Covered Services, excluding Experimental Services;

b. Copayments and deductibles or amounts in excess of any yearly or lifetime maximum applicable to Covered Services as specified in applicable Certificates. Hospital will not waive copayments, deductibles or amounts in excess of any yearly or lifetime maximum that are the responsibility of the Member, except for hardship cases that are documented in the Member's record, or where reasonable efforts to collect have failed;

c. Amounts attributable to Non-Reimbursable Covered Services or Experimental Services in those limited situations where the Member specifically agrees in writing in advance of receiving such services to the following: (i) the Member acknowledges that BCBSM will not make payment for such services, (ii) the Member consents to receipt of such services, and (iii) the Member assumes financial responsibility for such services;

d. Amounts attributable to Non-Reimbursable Covered Services in those limited situations where a Member who is a Hospital inpatient refuses to leave the Hospital following a documented determination by the Member's physician that acute care services are no longer necessary, regardless of whether the Member assumes financial responsibility for such services in writing in advance of the receipt of such services;

e. Amounts attributable to Covered Services where Hospital, despite its best efforts to determine whether an individual is a Member, is not informed that an individual is a Member; or

f. Amounts attributable to Covered Services if all of the following requirements are met: (i) Hospital documents that a bill was not submitted to BCBSM within twelve (12) months because a Member failed to provide proper identifying information, (ii) Hospital submits the bill to BCBSM for payment consideration within three (3) months after obtaining the necessary information, and (iii) BCBSM does not authorize payment by reason of the late submission.

Except for Non-Covered Services, Experimental Services and those Covered Services and Non-Reimbursable Covered Services enumerated above, Hospital shall not require deposits from Members. For Non-Covered Services, Experimental Services and those Covered Services and Non-Reimbursable Covered Services enumerated above, Hospital may require a reasonable deposit.

8. Claims Submission. Hospital shall submit claims for Covered Services to BCBSM using standard, electronic formats and codes as approved through National and State Uniform Billing Committees.

a. Claims shall comply with the requirements as stated in published BCBSM administrative manuals or additional published guidelines or criteria.

b. Hospital shall submit Clean Claims for Covered Services promptly after discharge or transfer of the Member or date of an outpatient service. The terms "discharge" and "transfer" apply to Hospital inpatient Covered Services. Original claims and modifications to that claim for Covered Services shall be billed within twelve (12) months after the date of discharge, transfer or service.

c. Notwithstanding the foregoing, after the expiration of the 12-month claim submission period, a Hospital claim may be initially billed to BCBSM within three (3) months after any one or more of the following has occurred:

i. Hospital obtains the necessary information to bill BCBSM and documents that a bill was not submitted within the applicable claim submission period because Hospital reasonably believed that BCBSM was secondary to another payer; or

ii. Hospital obtains the necessary information and documents that a Member failed to provide proper identifying information after an appropriate request was made prior to expiration of the effective claim submission period; or

iii. BCBSM is the secondary payer.

9. Coordination of Benefits and Other Party Liability. Hospital shall cooperate with BCBSM regarding coordination of benefits. Hospital procedures shall include admission and billing practices which ask Members for duplicate coverage or information necessary to determine coordination of benefits.

Hospital shall notify BCBSM of any and all known duplicate coverage obtained from such procedures by so indicating in the claims submission process.

a. If Hospital knows that another party is primary and BCBSM is secondary, Hospital shall first bill that party and shall notify BCBSM of all inpatient Covered Services for which that party assumed primary liability under a claims reporting procedure to be established by BCBSM, with any secondary BCBSM payment liability to be paid to Hospital by BCBSM.

b. In all other situations, Hospital shall first bill BCBSM, with BCBSM payment to Hospital to be made subject to Article III, Section 7.

10. Recordkeeping Requirements. Hospital shall prepare and maintain all appropriate medical and financial records related to Covered Services to Members and as required by law.

11. Notification and Escrow Requirements. Hospital shall comply with the following requirements:

a. Notification. Hospital shall notify BCBSM thirty (30) days in advance of the effective date of the following:

i. Changes in ownership or corporate structure, including the nature of the transaction and names of successor owners;

ii. The filing of a petition for relief under the U.S. Bankruptcy Code, appointment of a trustee, receiver or any action taken to dissolve, liquidate, terminate, consolidate, merge or sell all or substantially all of Hospital's assets;

iii. A twenty (20) percent or more reduction in the number of admissions or outpatient services in any six (6) month period;

b. Reporting. Each year Hospital shall fully complete and send to BCBSM the Medicare Cost Report, the BCBSM cost report, Audited Financial Statements and any other supporting documentation that may be reasonably requested by BCBSM.

c. Transfer of Hospital Assets. Hospital shall give BCBSM written notice as early as possible before Hospital transfers all or substantially all of its assets if the acquiring entity does not expressly assume Hospital's liabilities to BCBSM, or the acquiring entity is neither (1) a Participating Hospital nor (2) a Hospital commonly controlled legal entity, such as a parent or sister corporation or entity. Hospital and BCBSM shall agree upon an amount that shall be escrowed from the proceeds of such transfer to cover any outstanding liability to BCBSM.

12. Overpayments. Hospital shall promptly report and refund to BCBSM through a process identified by BCBSM any Overpayment under this Agreement discovered by Hospital. In lieu of a refund, Hospital may request BCBSM to offset the overpayment against future payments due Hospital under this Agreement

13. Access to Records.

a. Filing Requirements.

i. Hospital shall provide BCBSM with a cost report and an electronic version of its submitted Medicare Cost Report within one hundred eighty (180) days after the end of its fiscal year or at the time the Medicare Cost Report is submitted, whichever is later. A copy of the signed Medicare Cost Report signature page shall be provided.

ii. Hospital shall provide a complete set of audited Hospital and corporate financial statements, if available, at the same time as the Medicare Cost Report is submitted.

iii. Hospital shall provide BCBSM access to other financial reports and information as needed to administer this Agreement. These include but are not limited to Hospital charge master, adjusted trial balance, trial balance roll-up schedules and intern and resident schedules.

iv. Failure to comply with any of the above requirements will result in an immediate halt to all cash payments to Hospital pursuant to this Agreement. Cash payments will immediately resume when Hospital complies with the above requirements.

b. Coding and Documentation.

i. BCBSM shall establish acceptable performance levels related to hospital outpatient coding and documentation. Recovery shall be made for all cases where coding and documentation errors are found. The error results and recovery shall not be extrapolated. Coding errors shall be aggregated to determine the net amount to be recovered by BCBSM or refunded to Hospital.

ii. BCBSM shall establish a process that validates the accuracy of DRG coding by hospitals. This DRG validation process shall utilize nationally accepted coding guidelines. Coding errors shall be aggregated to determine the net amount to be recovered by

BCBSM or refunded to Hospital (recovery shall not be based on extrapolation).

iii. All other audits conducted by BCBSM, including but not limited to audits of readmissions and non-acute cases, shall utilize nationally accepted guidelines (and shall be subject to recovery on a case-by-case basis and not based on extrapolation).

c. Compliance Penalties. Under the following circumstances, BCBSM shall be authorized to recover amounts equal to three times the identified Overpayments. BCBSM shall not impose treble damages based on the amount of extrapolated Overpayments. For this provision to apply, all of the following conditions must be met:

i. The Overpayment must be identified through an audit described in Article II, Section 13.b.i. 13.b.ii. or 13.b.iii. above, or result from an error on a financial statement or report submitted to BCBSM.

ii. BCBSM shall have determined that there is a pattern or practice of errors by Hospital resulting in Overpayments that is persistent and recurrent in nature, and BCBSM shall have notified Hospital in writing that Hospital will be subject to treble damages if, following a reasonable period of time to take corrective action, the pattern or practice is not corrected. Treble damages shall not apply with respect to Overpayments which arise out of Hospital actions taken before notice and expiration of a reasonable amount of time to take corrective action.

iii. The Overpayment does not arise out of a legitimate dispute between Hospital and BCBSM.

iv. The decision to impose the treble damage penalty is reviewed and approved by the Internal Review Committee.

Article III
BCBSM Responsibilities

1. General Responsibility. BCBSM shall have the following obligations and such other obligations as are established by or pursuant to this Agreement.

2. Scope of Responsibility. BCBSM's payment obligations under this Agreement will be governed by the Reimbursement Policies and in the same manner as Hospital's scope of responsibility as provided in Article II, Section 4. The discounts under this Agreement shall apply only to services provided to a Member issued a BCBS identification card.

3. Member Identification. BCBSM shall provide identification cards to Members. BCBSM shall provide Members, at the time of enrollment and in advance of each relevant change in procedures, coverage and obligations subsequent to enrollment, with written information necessary to accurately and adequately inform Members of the procedures for obtaining Covered Services from Hospital and of their obligations to Hospital with respect to copayments, deductibles and Non-Covered Services, among other matters.

4. Eligibility, Coverage and Benefit Verification; Prenotification. Hospital shall be provided with a system and/or method for verification of eligibility, coverage and benefits (including information on copayments and deductibles), and for Prenotification. The system and/or method shall be accessible to Hospital on a 24-hour, 7-day-per-week basis, except during periods of routine maintenance. Eligibility, coverage and benefit verification information shall be provided as a service and not as a guarantee of payment.

5. Claims Processing. Claims shall be processed and paid by BCBSM to Hospital in forty five (45) days in accordance with the terms of this Agreement.

6. Coordination of Benefits and Other Party Liability. As provided in Article II, Section 9 (b), where Hospital does not know that another party is primary and Hospital first bills BCBSM, one of the following shall occur:

   a. For BCBSM customers that have a Pay and Pursue coordination of benefits program in which coordination of benefits activities are performed on a post-payment basis, BCBSM shall accept the claim, process the claim and pay Hospital in accordance with the Reimbursement Policies.

   b. For BCBSM and BCBSM customers that have a Pursue and Pay coordination of benefits program in which coordination of benefit activities are performed on a pre-payment basis, BCBSM shall accept the claim and process the claim by pending the claim. During the time the claim is pended, BCBSM shall investigate coordination of benefits obligations. After the claim has been accepted, pended and investigated by BCBSM, BCBSM shall pay the claim in accordance with this Agreement and the Reimbursement Policies if BCBSM is primary and reject the claim if another party is primary. When a claim is submitted, pended and investigated, BCBSM shall apply its payment rule policy to determine primary and secondary liability, as the same may change from time to time, in a coordination of benefits situation in which both the "birthday" rule and the "gender" rule are in effect.

      In those situations where BCBSM is secondary, BCBSM shall reimburse Hospital for its secondary balance in accordance with this Article III, Sections 7 and 8 and the Reimbursement Policies.

7. BCBSM Payment for Covered Services to Members. BCBSM shall make direct payments to Hospital for Covered Services provided to Members in accordance with the Reimbursement Policies.

   a. BCBSM shall not pay Hospital in the following situations:

      i. Where Non-Covered Services are provided to Members;

      ii. Where Non-Reimbursable Covered Services are provided to Members, except as provided in this Article III, Section 8.

   b. Where (i) coordination of benefits and other party liabilities are applicable and (ii) BCBSM is secondary, BCBSM shall pay Hospital at the lesser of BCBSM's approved amount for Covered Services net of the other party's

payment and the Member's copayments and deductibles or the amount submitted by Hospital as its secondary balance. However, in no event shall BCBSM payment exceed the amount payable under Reimbursement Policies. Where there are two separate contracts involved which are both with BCBSM, BCBSM shall pay Hospital in accordance with Reimbursement Policies.

c. BCBSM shall make weekly prospectively determined interim payments ("BIP") to Hospital. In the event that BIP payment dates fall on a holiday or weekend, such payment will be made on the next business day. BIP payments are subject to determination, adjustment and reconciliation in accordance with Reimbursement Policies and to BCBSM's right of recovery as provided in Article VI.

d. If BCBSM is temporarily unable to meet its financial obligations arising out of this Agreement, such obligations shall be construed as a continuing liability to Hospital to be satisfied within a reasonable time, subject to Hospital's rights of termination pursuant to Article V, Section 2. This section shall not be construed to limit or remove any rights that Hospital may have with respect to late BCBSM payments as a matter of law.

e. Where an inpatient admission is a high-cost catastrophic case, as defined in the Reimbursement Policies, and the inpatient admission was appropriate because acute care as an inpatient was necessary due to the kind of care the Member required and safe and adequate care could not be received as an outpatient or in a less intensified medical setting but certain services received during the course of the inpatient admission were not Medically Necessary, BCBSM will pay Hospital in accordance with the Reimbursement Policies but BCBSM may reduce Hospital's high-cost catastrophic case payment by the amount of the services determined to be not Medically Necessary.

8. BCBSM Payment for Non-Reimbursable Covered Services. BCBSM shall pay Hospital for Non-Reimbursable Covered Services in the following limited situations:

a. Where Precertification determined appropriateness of inpatient level of care, BCBSM shall pay for the inpatient admission in accordance with the Reimbursement Policies, even if upon retrospective Review, BCBSM determines that an inpatient level of care was not required, so long as Covered Services met all other components of the Medical Necessity determination, inpatient intensity of service was delivered, and if applicable, the documentation in the medical record is consistent with the notes from the Precertification approval.

b. Where Precertification was not performed and any retrospective Review conducted pursuant to Exhibit C subsequently determines that the Covered Services met all components of the Medical Necessity determination except that an inpatient level of care was not required, BCBSM will pay for Covered Services at the appropriate outpatient rate in accordance with the Reimbursement Policies.

9. Participating Hospital Lists, Directories or Other Information. BCBSM shall include Hospital's name and other appropriate identifying information in any lists,

directories or other information provided to Members or third parties for so long as Hospital is a Participating Hospital. BCBSM shall not include Hospital's name or other identifying information in any lists, directories or other information provided to third parties which might reasonably be construed to suggest that Hospital is a member of a network of hospitals of an HMO, PPO or POS owned or controlled in whole or in part by BCBSM or one of its subsidiaries unless Hospital has also signed a separate agreement with BCBSM to participate in such network.

10. Administrative Manuals and Bulletins. BCBSM shall at no charge provide Hospital with one hard copy of or, when available, electronic access to all current and historical administrative manuals, bulletins, and such other documents and information as may be reasonably necessary for Hospital to effectively and efficiently furnish Covered Services to Members and be paid therefore. BCBSM shall also provide Hospital with Certificates upon request.

11. Customer-Specific Programs. At the request of a customer, BCBSM will establish and administer Customer-Specific Programs. BCBSM will use its best efforts to make Customer-Specific Programs uniform and standardized. The following provisions will apply with respect to Customer-Specific Programs:

    a. Unless otherwise agreed to by Hospital, if a Customer-Specific Program provides that one or more services (except mental health and substance abuse) otherwise subject to reimbursement under this Agreement will be reimbursed under a different agreement, then this Agreement will not apply to any other services Hospital provides to the customer's members.

    b. This Agreement will apply to services provided by Hospital to Members enrolled in Customer-Specific Programs that use an entity other than BCBSM or its subcontractor to administer a component of the PHA involving Precertification, Recertification, Prenotification, Retrospective Utilization Review or claims processing. If participation in such a program will involve substantial administrative burden, BCBSM will implement an industry-wide payment increase on a customer-specific basis to compensate hospitals for the additional costs and/or complexity involved in complying with the program as determined through the CAP.

    c. Hospital will participate in all reasonable Customer-Specific Programs that involve Audits and Reviews to ensure the accuracy of payments under this Agreement. Customer-specific Audits and Reviews may involve customer-selected contractors. In such cases, BCBSM will coordinate the interface between the contractor and Hospital. BCBSM will work with customers to ensure any customer-specific Audits and Reviews do not duplicate existing BCBSM Audits and Reviews.

12. Advertising and Publication. BCBSM may advertise and publicize the names of Participating Hospitals.

Article IV
Contract Administration Process

1. Establishment. BCBSM hereby establishes an ongoing Contract Administration Process ("CAP") through which Hospital and other Participating Hospitals may provide non-binding input and recommendations to BCBSM with respect to all decisions, matters and activities within the jurisdiction of the CAP, to the extent allowed by law. BCBSM commits to give significant consideration to input from the CAP.

2. Amendments to the Agreement. This Agreement may be amended by BCBSM and Hospital as set forth in Article V, Section 5. In addition, if the BCBSM board of directors approves, as presented, a recommendation of the PHA Advisory Committee to amend this Agreement, it shall become a binding part of this Agreement after not less than thirty (30) days written notice to Hospital. Additional notice may, at BCBSM's option, be published in an appropriate BCBSM provider publication (e.g. *The Record or* web-DENIS).

3. Applicability of the Contract Administration Process.

   a. The CAP applies to all existing and future BCBSM standard and Customer-Specific Programs affecting Hospital services under this Agreement.

   b. Any action which BCBSM takes with respect to the following matters must be mutually agreed upon by BCBSM and Hospital. Alternatively, action by BCBSM with respect to any of the following matters shall be binding on the Hospital if such action is consistent with the non-binding input and recommendations of the appropriate CAP committee:

      i. Pay-for Performance programs oversight;

      ii. Utilization, Quality and Health Management Programs, including without limitation standards, reporting guidelines, medical record reviews and interventions;

      iii. Centers of Excellence requirements;

      iv. Reimbursement Policies;

      v. Notification requirements;

      vi. Reviews and Audits, including the payment to be made by BCBSM for copies of medical and billing records;

      vii. Methods of payment;

      viii. Claims reporting;

ix. Financial Reporting requirements for hospitals;

x. Billing procedures;

xi. Claims processing;

xii. Systems and/or methods for verification of eligibility, coverage and benefits;

xiii. Prenotification, Precertification and Recertification;

xiv. Qualification standards;

xv. Determination of the reasonableness of Customer-Specific Programs under Article III Section 11;

xvi. Compliance with performance, reporting and billing standards, and acceptable performance levels for coding and documentation for purposes, among others, of imposition of treble damages on Hospital;

xvii. Appeals;

xviii. The adoption, rescission, implementation or modification by BCBSM of manuals, implementation schedules, criteria, guidelines, policies, standards and timeframes for Hospital action with respect to matters to which this Agreement applies; and

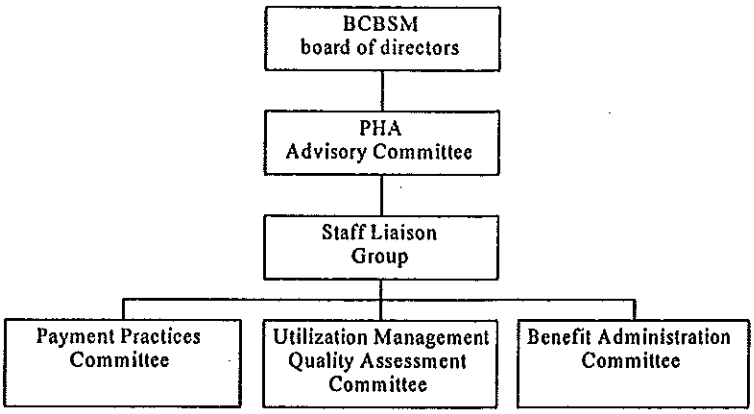
xix. Any other matters to which the CAP applies pursuant to the terms of this Agreement.

4. Non-Applicability of the Contract Administration Process. The CAP does not apply to changes in any BCBSM health care benefits and benefit structures.

5. Organization. The Contract Administration Process shall be organized through the following committees: (i) Participating Hospital Agreement ("PHA") Advisory Committee, (ii) Utilization Management and Quality Assessment Committee, (iii) Payment Practices Committee, (iv) Staff Liaison Group, (v) Benefit Administration Committee and (vi) such additional committees as may be established to report to or through these committees from time to time.

In addition to providing non-binding input and recommendations to BCBSM pursuant to the Contract Administration Process, certain committees, as may be approved by BCBSM from time to time, shall make recommendations to BCBSM with respect to appeal activities or such other activities as may be authorized by BCBSM from time to time.

The organization of the Contract Administration Process is graphically depicted as follows:



6. Participating Hospital Agreement ("PHA") Advisory Committee. A PHA Advisory Committee shall be established to provide non-binding input and recommendations regarding the implementation/administration and any modifications of the Participating Hospital Agreement, Exhibits and BCBSM administrative manuals as may be proposed from time to time. The PHA Advisory Committee shall have jurisdiction over all matters to which the Contract Administration Process applies. The PHA Advisory Committee shall, among other things:

   a. Make non-binding recommendations regarding the coordination and review of actions of the Utilization Management and Quality Assessment and Payment Practices Committees;

   b. Forward non-binding recommendations to the BCBSM board of directors on any matters relating to the Agreement or the relationship between BCBSM and Participating Hospitals;

   c. Make non-binding recommendations regarding the resolution of differences that may arise in the Benefit Administration, Utilization Management and Quality Assessment and Payment Practices Committees;

   d. Make non-binding recommendations to changes in Reimbursement Policies;

   e. Discuss and make non-binding recommendations to BCBSM on public policy issues affecting health care delivery and proposed changes in BCBSM health care benefits and benefit structures;

   f. Entertain appeals by Hospital or groups of hospitals on all matters within the scope of the Agreement, excluding those appeals covered under Exhibit D, in accordance with the appeal procedures set forth in BCBSM administrative manuals and make non-binding recommendations to the BCBSM board of directors with respect to such appeals;

g. Adopt and amend from time to time policies to address conflicts of interest that may arise when CAP committee representatives affiliated with hospitals that own PPOs or other managed care products are asked to consider issues related to BCBSM PPOs or other managed care products. The policies shall include provisions for disclosure of potential conflicts by committee members as well as provisions for abstention from discussions and providing input and recommendations on particular matters; and

h. Provide non-binding input and recommendations to further the relationship between BCBSM and Participating Hospitals.

The PHA Advisory Committee shall consist of equal numbers of persons appointed by BCBSM and the Michigan Health and Hospital Association ("MHA"). BCBSM appointees shall not include BCBSM staff and shall include at least one (1) public member of the BCBSM board of directors and at least one (1) small group or non-group member of the BCBSM board of directors. MHA appointees shall not include MHA staff and shall include at least one (1) member of the MHA corporate board. Staff from both BCBSM and MHA shall participate as invited guests.

The PHA Advisory Committee shall meet on an ad hoc basis at the request of either BCBSM, MHA, Hospital or group of hospitals exercising appeal rights in accordance with BCBSM appeal procedures.

7. Staff Liaison Group. A Staff Liaison Group shall be established consisting of the co-chairpersons of the Benefit Administration Committee, Utilization Management and Quality Assessment Committee and Payment Practices Committee. The Staff Liaison Group will meet as necessary to oversee and coordinate the activities of these three committees and to develop recommendations for and report to the PHA Advisory Committee. To the extent that each matter, action or activity to which the Contract Administration Process applies is relevant or reasonably related to more than one committee, it shall be under the jurisdiction of each relevant Committee and coordinated by the Staff Liaison Group before presentation to, and recommendation by, the PHA Advisory Committee.

8. Payment Practices Committee. A Payment Practices Committee shall be established consisting of equal numbers of persons appointed by BCBSM and MHA. The Payment Practices Committee shall be composed of BCBSM senior and mid-level management responsible for the activities within the jurisdiction of this Committee and MHA staff, augmented by representatives from Participating Hospitals with expertise in the activities within the jurisdiction of the Committee. All matters, actions and activities to which the Contract Administration Process applies which are relevant or reasonably related to payment practices shall be within the jurisdiction of this Committee. The Committee shall meet as necessary to discuss payment administration and policy issues.

9. Utilization Management and Quality Assessment Committee. A Utilization Management and Quality Assessment Committee shall be established consisting of equal numbers of persons appointed by BCBSM and MHA. The Utilization Management and Quality Assessment Committee shall be composed of BCBSM senior and mid-level management responsible for the activities within the

jurisdiction of this Committee and MHA staff, augmented by representatives from Participating Hospitals with expertise in the activities within the jurisdiction of the Committee. All matters, actions and activities to which the Contract Administration Process applies, which are relevant or reasonably related to utilization, quality and health management, shall be within the jurisdiction of this Committee. The Utilization Management and Quality Assessment Committee shall meet as necessary.

10. Benefit Administration Committee. The Benefit Administration Committee shall be established to provide input to BCBSM on administrative issues and to act in a joint manner to solve problems related to administrative issues. The Committee shall consist of administrative staff appointed by BCBSM and such Participating Hospital personnel and MHA staff appointed by MHA. The Benefit Administration Committee shall meet as necessary.

11. Special Work Groups and/or Task Forces. On occasion, issues which cut across the committees described above shall be reviewed through the Contract Administration Process. When deemed appropriate by either the Participating Hospital Agreement Advisory Committee or the Staff Liaison Group, special cross-jurisdictional work groups or task forces may be appointed to review such issues in place of, or in addition to, the standing committees. Non-binding recommendations for such groups shall be reported to the PHA Advisory Committee. Membership of such groups shall be appointed by the MHA and BCBSM, respectively.

Article V
General Provisions

1. Term. This Amended and Restated Agreement shall commence as of the later of July 1, 2009 or the effective date indicated on the attached Signature Document and shall continue until terminated as provided below.

2. Termination.

   a. This Agreement may be terminated as follows:

      i. By either Party, upon one hundred twenty (120) days written notice of intent to terminate. Such termination may be with or without cause;

      ii. By either Party, as provided in this Article V, Section 6, below;

      iii. By Hospital, at its option, in the event that BCBSM is unable to meet its financial obligations as set forth in Article III, Section 7(d), for a period of at least fifteen (15) consecutive days and Hospital provides BCBSM with thirty (30) days advance written notice of termination;

iv. By either Party, if any voluntary or involuntary petition or similar pleading under any chapter of the United States Bankruptcy Code shall be filed by or against either Party, or any voluntary or involuntary proceedings in any court or tribunal shall be instituted to declare either party insolvent or unable to pay its debts, and in the case of the involuntary petition or proceedings, the petition or proceeding is not dismissed within sixty (60) days from the date it is filed, the other Party may terminate this Agreement upon written notice to Hospital or BCBSM, as the case may be, effective upon receipt of such notice;

v. By Hospital or by BCBSM, immediately in the event that Hospital ceases to do business or ceases providing Covered Services to Members;

vi. By BCBSM, immediately, if Hospital loses its licensure or Hospital fails to meet the Qualification Standards in Exhibit A, provided that the Agreement shall be terminated only with respect to that portion of Hospital facility not in compliance with licensure or Qualification Standards;

vii. By BCBSM, immediately, if Hospital is not allowed to participate in federal or state health care programs;

viii. By either party at any time, in the event of a breach of any material term, condition, warranty or representation of this Agreement that is not cured within 30 days of the detailed written notice of the cause of the breach.

b. In the event that this Agreement terminates for any reason, Hospital shall continue to furnish Covered Services to any Member who is a Hospital inpatient on the effective date of such termination until discharge or transfer from Hospital in accordance with Article II, Section 4, except for termination due to Hospital's loss of licensure. BCBSM shall pay Hospital for such inpatient Covered Services in accordance with the terms of this Agreement.

3. Assignment. Any assignment or delegation of rights or duties arising out of this Agreement by either Party without the prior written consent of the other Party shall be void. No assignment of Hospital's or BCBSM's rights and duties under this Agreement shall be approved unless assignee agrees to assume in writing all liabilities of the assignor under this Agreement.

4. Prior Agreements. This Agreement is the entire agreement between the parties regarding matters contained herein and supersedes any other discussion and agreements. However, this Agreement will have no effect on any Hospital-specific contract amendments that were entered into prior to and whose term extends past the effective date of this Agreement.

5. Amendments. This Agreement or any part or section of it may be amended at any time during the term of the Agreement by mutual consent in writing of the duly authorized representatives of BCBSM and Hospital.

6. Severability. In the event that any provision of this Agreement is rendered invalid or unenforceable by any state or federal law, rule or regulation or by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall remain in full force and effect. In the event that a provision of this Agreement is rendered invalid or unenforceable and its removal has the effect of materially changing the obligations of either party in such manner as, in the judgment of the Party affected, (i) will cause serious financial hardship to such Party, or (ii) cause such Party to act in violation of its corporate articles of incorporation or bylaws, the Party so affected shall have the right to terminate this Agreement upon thirty (30) days written notice to the other Party.

7. No Third Party Rights/Limited Enforcement. This Agreement is intended solely for the benefit of the Parties hereto, and there is no intention, express or otherwise, to create rights or interests for any Party or persons other than BCBSM and Hospital. This Agreement shall be enforceable only by the Parties hereto and no other person shall have the right to enforcement of the provisions contained herein, including without limitation, any BCBSM customer, Member or any other individual.

8. Waiver of Breach. Waiver of breach of any provision of this Agreement shall not be construed as a continuing waiver of such breach or a waiver of any other breach of the same or a different provision.

9. Entire Agreement. This Agreement, as it may be amended from time to time, together with any and all Exhibits, contains the entire Agreement between the Parties.

10. Non-Exclusivity. The Parties acknowledge that this Agreement does not in any manner limit either Party from entering into similar agreements with other parties.

11. Names, Symbols, Trademarks and Service Marks. The Parties each acknowledge the proprietary nature of and reserve the right to and the control of their respective names, symbols, trademarks and service marks now existing or later established. The Parties agree that neither shall use the other's name, symbols, trademarks and service marks, except as otherwise provided in this Agreement, without the prior written consent of that Party and shall cease any such impermissible usage immediately upon notice from the other Party or upon termination of this Agreement.

12. Section Headings. The section headings used herein have been inserted for convenience of reference only and shall not in any way modify or restrict any of the terms or provisions hereof.

13. Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Michigan. In the event of any unresolved dispute, jurisdiction will be in Michigan.

14. Notices. Any notice required or permitted under this Agreement shall be given in writing and sent to the other Party by hand-delivery, or postage prepaid regular mail at the following address or such other address as a Party may designate from time to time.

If to Hospital:

Hospital's name and address on
BCBSM provider file.

If to BCBSM:

Provider Contracting Department B715
Blue Cross Blue Shield of Michigan
27000 West 11 Mile Road
Southfield, Michigan 48034

15. Independent Contractor Clause. BCBSM and Hospital are independent entities. Nothing in this Agreement shall be construed as, or be determined to create, a relationship of employer and employee, or principal and agent, joint ventures, partners or any relationship other than that of independent parties contracting with each other solely for the purposes of carrying out the provisions of this Agreement.

16. BCBSA Status Disclosure Clause. This Agreement is between Hospital and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans, permitting BCBSM to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by accepting this Agreement, Hospital agrees that it made this Agreement based only on what it was told by BCBSM or its agents. Only BCBSM has an obligation to Hospital under this Agreement and no other obligations are created or implied by this language.

17. Compliance with Laws and Administrative Manuals. Both parties shall comply with all applicable laws and regulations. In addition, both parties shall comply with BCBSM administrative manuals as they may be developed, implemented and modified from time to time under the CAP. In addition, both parties will comply with BCBSM policies upon 60 days written notice. Such notice will be given by publication in either *The Record* or web-DENIS.

Article VI
Reviews, Audits and Recoveries

1. Reviews and Audits. Subject to all applicable laws and the confidentiality provisions set forth in Article VII of this Agreement, Hospital shall allow BCBSM to conduct the following Reviews and Audits. Reviewers shall use their best efforts to minimize disruption to normal Hospital operations while conducting such Reviews and Audits.

a. Medical Record and Billing Reviews. Hospital shall allow BCBSM to conduct reasonable Reviews of Hospital's medical and billing records related to Covered Services provided to Members under this Agreement. Hospital shall receive 30 days advance written notice from BCBSM advising Hospital of the Review and setting forth the scope of the medical and billing records to be reviewed. Hospital shall provide BCBSM with on-site access during Hospital's regular business office hours to all appropriate medical and billing records of Covered Services to Members as may be necessary for benefit determination and/or verification of compliance with the requirements of the Utilization, Quality and Health Management Programs. At the request of BCBSM, Hospital shall provide BCBSM with copies of such requested medical and billing records within a reasonable time from the date of request and in exchange for reasonable payment. All Reviews shall be initiated and completed, including receipt by Hospital of a final Notice of Determination, within 18 months from the date of payment, excluding cases under appeal. The results of findings resulting from any Review undertaken pursuant to this Section shall be submitted in writing to Hospital's Chief Financial Officer, or designee, for comment.

b. Financial Audits. Hospital shall allow BCBSM to conduct reasonable Audits of Hospital's financial records. Such financial Audits shall be initiated and completed within 18 months of the filing of an acceptable cost report with BCBSM by Hospital. Hospital shall provide BCBSM with on-site access during Hospital's regular business office hours to all appropriate financial records as may be necessary for establishing appropriate payment liabilities. Hospital shall authorize its independent public accountants to share work papers, reports and other documents (except for third party reserve work papers) utilized in its annual financial audits as may be relevant to BCBSM's determination of appropriate payment liabilities. The findings resulting from any financial Audit undertaken pursuant to this Section shall be discussed with Hospital's Chief Financial Officer, or designee, in an exit conference prior to being subsequently submitted to Hospital's Chief Financial Officer, or designee, in writing for review.

2. Recovery.

a. Subject to the time limitations in Article VI, Section 1.a., BCBSM shall have the right of recovery if payments made by BCBSM are subsequently determined to have been erroneous pursuant to any Reviews conducted under this Agreement, except for Reviews associated with the incentive system.

b. Subject to the time limitations in Article VI, Section 1.,b, BCBSM shall also have a right of recovery for amounts resulting from a Financial Audit.

c. BCBSM shall have the further right to recover the amount of all Overpayments and other amounts ("BCBSM Receivables") due it under all contracts between BCBSM and Hospital through recoupment of and setoff against amounts due to Hospital from BCBSM under this Agreement.

d. Hospital shall have the right to recover the amount of all Underpayments and other amounts (Hospital Receivables) due it under all contracts between BCBSM and Hospital through recoupment of and set-off against amounts due to Hospital from BCBSM under this Agreement.

e. The expiration or termination of this Agreement shall not terminate or otherwise limit BCBSM's right of recovery from Hospital as set forth in this Article, or under any other provision of this Agreement. Upon termination or expiration of this Agreement, BCBSM may withhold an amount equal to reasonably anticipated BCBSM Receivables until a final audit is completed. In the event the final audit determines that Hospital owes BCBSM money, BCBSM may apply the withheld BCBSM Receivables against any amounts due to BCBSM under this Agreement or otherwise. BCBSM shall promptly pay to Hospital all withheld amounts in excess of the amounts due to BCBSM under this Agreement or otherwise.

3. Other Recoveries. Except for those situations indicated below, BCBSM recoveries for payments made to hospitals in error will be limited to two years from the original date of payment. Exceptions to this policy include verified duplicate and overpayments, workers' compensation cases, credits uncovered through fraud investigations, payments where BCBSM was verified in error as the primary insurer, payments issued to the wrong facility and payments for services not performed. Additional exceptions will be subject to CAP review.

Article VII
Confidentiality

1. Medical and Administrative Records.

a. Preparation and Maintenance. Hospital will prepare and maintain medical and administrative records relating to its provision of Covered Services to Members, in such form and detail as is required by BCBSM, applicable medical standards and applicable law. Hospital will retain all Member medical records for at least as long as applicable law requires.

b. Confidentiality.

i. Hospital Requirements. Hospital will treat as confidential all Member medical records and the information contained therein, as well as aggregate data that could implicitly identify an individual. In accordance with its internal policies and procedures, and as required by law, Hospital will obtain appropriate consent from Members for release of medical records or any of the information contained therein to third parties.

ii. BCBSM Requirements. BCBSM will maintain confidentiality of Member-specific information, as well as aggregate data that could implicitly identify a Member. As a condition precedent to receiving benefits under a Certificate, BCBSM will require Members to agree to release of medical information from physicians and Hospitals related to the provision of Covered

Services. BCBSM may disclose Member-specific information to a Group for purposes of claims adjudication and verification, provided the recipient executes a written confidentiality and indemnification agreement that restricts use of the information to the above purposes and prohibits further disclosure.

c. Access to Records. Hospital will permit BCBSM to have access during normal working hours to Members' medical and administrative records and upon reasonable request to inspect and copy any medical and administrative records maintained by Hospital pertaining to Members. Upon request, BCBSM shall reimburse Hospital a reasonable amount for copying costs associated with copying records for BCBSM.

2. Hospital-Specific Information.

a. BCBSM will maintain the confidentiality of, and will not disclose to any third party, Hospital-specific Agreement modifications, payment rates, and Hospital-specific business or financial information not otherwise available to the public ("Confidential Information"). Except where disclosure is required by law, BCBSM may disclose Confidential Information to another party only with the prior written consent of Hospital, specifying the conditions under which it may be released. However, BCBSM may, without prior written consent of Hospital, disclose Confidential Information as defined in this subsection to a customer for purposes of audit and health plan administration, or to the MHA for modeling and other contract administration purposes, so long as the customer and MHA agree to restrict its use of the information to these purposes and agrees not to further disclose the information.

b. Analyses of Hospital's performance under this Agreement, for example, its relative cost position vis-à-vis other hospitals or benchmarks and findings under any Utilization Management and Quality Assessment Program (including measures used for incentive purposes) will not be considered Confidential Information. BCBSM may use and disclose such information without further authorization from Hospital. However, when BCBSM develops such reports, it will seek the input of hospitals through the CAP and not disclose any such information to the public without providing to the physicians or hospitals, including Hospital identified in the disclosure, in advance, a copy of the information. BCBSM will provide Hospital and the identified physicians a reasonable opportunity to comment on findings related to them.

c. Notwithstanding the above, and subject to prior notice being given to hospitals through the CAP, BCBSM is permitted to release Hospital-specific health care data for the purpose of allowing Subscribers, Plan sponsors, customers, consultants, BCBSA, BCBS plans or other BCBSM business partners to relatively compare the cost and level of quality of care offered by the Hospital. Hospital-specific health care data may include, but shall not be limited to, the following:

i. Provider demographic information

ii. Utilization information

iii. Quality of care measures and initiatives

iv. Service volumes

v. Small area analysis

vi. Credentialing information

vii. Outcome measures

viii. Patient satisfaction results

ix. Costs and similar health care data

Hospitals agree to provide or assist in the provision of such provider-specific health care data as reasonably requested by BCBSM. Upon written request of Hospital, BCBSM shall make available to Hospital a description of how BCBSM intends to use a particular category of provider-specific health care data, the methodology used in collecting and analyzing the data and a copy of the Hospital's data which BCBSM intends to disclose. To the extent Hospital can reasonably demonstrate, in writing, that any data which BCBSM intends to disclose is inherently inaccurate, Hospital shall notify BCBSM of its specific concerns. BCBSM shall make a good faith effort to resolve Hospital's concerns, provided, however, that BCBSM shall have the sole and final discretion, responsibility and authority over the content, dissemination and release of such data.

3. Mutual Indemnification. Each Party will defend, indemnify and hold harmless the other, its directors, officers, employees and agents from any claims, losses, costs or expenses (including reasonable attorney fees) arising out of or in connection with breach of these confidentiality provisions by the other Party.

4. Hospital/Patient Discussions. Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations, Hospital shall not be prohibited from discussing fully with a Member any issues related to the Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by BCBSM or any other entity. Nothing in this Agreement shall prohibit Hospital from disclosing to the Member the general methodology by which Hospital is compensated under this Agreement, provided no dollar amounts or other specific terms of the compensation arrangement are mentioned to the Member. BCBSM shall not refuse to allow or to continue the participation of any otherwise eligible provider, or refuse to compensate Hospital in connection with services rendered solely because Hospital has in good faith communicated with one or more of its current, former or prospective patients regarding the provisions, terms or requirements of a Certificate as they relate to the health needs of such patient.

5. Survival of Terms. The obligations and duties set forth in this Article shall survive the termination of this Agreement.

This Agreement is proprietary and confidential. Exhibit B of this Agreement can be released to Hospital's agents, contractors or consultants only if these parties sign a statement agreeing not to disclose the Agreement to third parties. Hospital cannot disclose Exhibit B to any other third parties without the prior written consent of BCBSM.

IN WITNESS WHEREOF, the Parties hereby execute this Agreement by affixing their signatures to the attached Signature Document.

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF

Exhibit A

QUALIFICATION STANDARDS

I. **Scope of Qualification Standards:**

A. These Qualification Standards apply to Hospitals providing short term general acute care, short-term acute psychiatric care and intensive rehabilitation programs and only to services, beds and facilities that are included within the scope of Hospital's license. Separate qualification standards have been established for sub-acute services of Hospital not included within the scope of Hospital's license.

II. **Licensure, Certification, Accreditation:**

A. Hospital must be licensed as required by the laws of the State of Michigan.

B. Hospital must comply with the certification standards established by the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) for participation in the Medicare Program.

C. Hospital must be accredited by the Joint Commission, the American Osteopathic Association (AOA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or Det Norske Veritas (DNV) or such other accreditation organizations as may be approved through the CAP, unless Hospital is located in a rural census category. If Hospital is located in a rural census category, the accreditation requirements set forth in this subsection may be waived at the request of Hospital, if Hospital demonstrates that CMS certified Hospital's compliance with Medicare certification requirements on the basis of a survey conducted by an appropriate state agency.

III. **Certificate of Need:**

Hospital must comply with applicable Certificate of Need requirements of the Michigan Public Health Code.

IV. **Sponsorship, Ownership and Control:**

Hospital must have a governing body that is legally responsible for the conduct of the hospital. Hospital must have a governing body, or advisory body responsible to the governing body, that includes persons generally representative of the community in Hospital's service area.

V. **Financial**

Hospital shall follow generally accepted accounting principles and practices.

VI. **Utilization Management and Quality Assessment**

Hospital shall have programs of utilization management and quality assessment.

Exhibit B

REIMBURSEMENT

I. Implementation

Unless otherwise indicated, the following inpatient and outpatient reimbursement methodologies will be effective with the start of Hospital's fiscal year beginning on or after July 1, 2006.

II. Peer Groups

Hospitals will be categorized into one of the following peer groups:

PEER GROUP	HOSPITAL CHARACTERISTICS
1	Meet two of the following: - 50 or more full time equivalent (FTE) interns and residents - 325 or more licensed beds
2	Meet one of the following criteria: - Fewer than 50 FTE interns and residents - 325 or more licensed beds
3	Meet one of the following two groups of criteria: - Group one - meet both criteria · Non-rural * hospital · Fewer than 325 licensed beds - Group two - meet both criteria · Rural* hospital · More than 150 licensed beds
4	Meet all of the following criteria: - Rural * hospital - 150 or fewer licensed beds - Not in Peer Group 5
5	Meet all of the following criteria: - Rural * hospital - 100 or fewer licensed beds - Total annual equivalent inpatient admissions of less than 6000** - Hospital is not a specialty or limited service hospital without emergency room services.

6	Meet one of the following criteria: - Licensed as a psychiatric hospital - Received psychiatric exempt unit status from Medicare
7	Meet the following criteria: - Received rehabilitation exempt hospital or unit status from Medicare

* United States Census Bureau definition of rural

** Total acute care, psychiatric and rehabilitation inpatient admissions plus outpatient admissions calculated as follows: Outpatient charges / (inpatient acute care charges per inpatient acute care admissions)

III. Model Reimbursement Methodology for Peer Group 1-4 Hospitals

A. Reimbursement Principles

Hospitals' inpatient and outpatient rates and the reimbursement policies that guide the development of these rates will be based on the following principles:

1. Base reimbursement will be set at a level that equates to ____over efficiently incurred generally accepted accounting principles (GAAP) hospital costs.

2. A Pay-for-Performance program (P4P) will pay top-performing hospitals up to an additional ____ of their inpatient and outpatient operating payments in the first year of the program and up to ____in the second year and up to ____ by the third year and thereafter. (Exhibit B, Section III, G)

3. BCBSM will compensate hospitals for a share of the cost of uncompensated care (bad debt and charity), plus an additional ____of the cost of uncompensated care on a statewide basis.

4. Hospitals' annual rate update will be based on a formula-driven process that reflects projected as well as actual cost increases (Exhibit B, Section IV).

5. Hospitals' reimbursement and cost levels will be assessed every three years to determine whether there is a need for pricing adjustments (Exhibit B, Section III, H).

6. BCBSM and hospitals will share information required to determine appropriate reimbursement levels under the BCBSM Model Reimbursement Methodology and to assist members' decision making on utilizing and paying for health care services.

7. The Model Reimbursement Methodology guiding principles apply to all BCBSM and BCN Traditional and managed care products.

Using the above principles as a guide, BCBSM has developed a Model Reimbursement Methodology for hospitals based on full-GAAP costs plus a margin. The Model also provides for additional payment associated with the hospital cost of uncompensated care and provides hospitals the opportunity to earn additional payment under a Pay-for-Performance program. Key elements of this model are described below:

B. Foundational Payment Model

The following payment model is the basis for the BCBSM hospital Model Reimbursement Methodology:

- Hospital cost ____ (a)
- Margin ____(b)
- Uncompensated care ____(c)
- Uncompensated care gross-up ____ (d)

Subtotal ____

- Pay for Performance ___ (e)

Total _____

- Other operating revenue offset ___ (f)
- BCBSM patient service reimbursement ____
-

(a) Full-GAAP cost less bad debt, calculated using BCBSM charges and departmental costs.

(b) Margin allowed on GAAP cost.

(c) Average statewide uncompensated care cost. The actual amount will be hospital specific and may be less than or greater than ____.

(d) Up to an additional ____ on a statewide basis associated with the cost of uncompensated care.

(e) Potential P4P earnings on inpatient and outpatient operating costs is up to an additional ____ in the first year of the program, up to ____ in the second year and up to ____ by the third year and thereafter.

(f) Other operating revenue offset against BCBSM costs. The actual offset will be hospital specific and may be greater than or less than ____.

C. Full-Cost Model

The purpose of the full-cost analysis is to determine BCBSM patient service reimbursement. The treatment of full-cost elements in hospitals' margin analysis is summarized below:

1. Full-Cost Process. The starting point of the full-cost process is the Medicare step-down analysis. This step-down analysis allocates "reimbursable" costs to the appropriate hospital departments. With the exceptions as noted below, Hospital "non-reimbursable" costs (the difference between total hospital expenses from audited financial statements and reimbursable costs from the Medicare step-down) are allocated to operating departments based on the percent to total from the Medicare step-down.

2. BCBSM Cost Allocation. The allocation of cost to BCBSM is based on BCBSM utilization of each department's services, i.e., BCBSM charges as a percent of total department charges applied to full stepped-down departmental costs and the departmentally allocated non-reimbursable costs.

3. Uncompensated Care. Hospitals will be reimbursed for a BCBSM share of their uncompensated care costs.

4. Physician Costs. Only A-8-2 adjustments that are related to reasonable compensation equivalent limits will be included in the hospital cost base.

5. Clinics. Clinic-related operating costs and revenues will be excluded from the analysis. However, hospital-direct GME costs will be allocated back to the hospital plus ____ of the balance of hospital overhead allocated to clinics through the Medicare step-down analysis.

6. Certified Nurse Anesthetists (CRNA). CRNA expense will be included in hospital costs after it is offset by CRNA net revenue.

7. Medicaid Tax. The Medicaid tax will be excluded from the hospital cost base.

8. Other Operating Revenue. Gifts, donations, investment income and revenue associated with non-hospital BCBSM provider class plans will not offset costs. With these exceptions, all Other Operating Revenue reported on hospitals audited financial statements will be subject to cost offset.

9. Non-Hospital Providers. Non-hospital ancillary services providers are excluded from the hospital cost base.

10. Nonrecurring Costs. Incremental costs associated with nonrecurring events or any significant or unusual expenses associated with loss or gain on sale of property and equipment is excluded from the hospital cost base.

D. Efficiency Measure and Margin Determination

1. The measure of hospitals' efficiency for determining the applicable margin and for P4P will be a standardized cost-per-inpatient admission.

2. Peer Groups 1-4 hospitals will be combined into a single peer group for comparison of standardized cost-per-inpatient admission.

3. Hospital inpatient costs will be standardized by adjusting for:

- Capital
- Bad Debt
- Medicare Wage Index, except 508 reclassifications
- Direct GME
- BCBSM Case-Mix Index
- Indirect Graduate Medical Education (GME)
- Catastrophic Payments
- A-8-2 Costs
- CRNA Costs

4. Hospital margin levels will be set based on each hospital's standardized cost-per-inpatient admission ranking relative to its peers. Hospitals with the lowest standardized cost-per-inpatient admission will be entitled to the highest margin while those with the highest standardized cost-per-inpatient admission will be reimbursed at the lowest margin. The following table shows the relationship between standardized cost-per-inpatient admission and margins that will be in effect at the initial implementation of the Model Reimbursement Methodology and whenever hospital reimbursement levels are recalibrated. Top-performing hospitals (i.e., those with the lowest standardized cost-per-inpatient admission) that comprise up to ____ of total statewide costs will earn the top-margin level of ____.

Margin Levels

Hospitals Comprising Stated Percent of Full-GAAP Costs	Margin
Top-performing hospitals comprising ___ of full-GAAP cost	
Top-performing hospitals comprising next	
Next	
Next	
Next	
Next	

5. Until such time that a process is finalized for evaluating efficiency performance for outpatient services, a hospital's inpatient margin percentage will also apply to outpatient services. Hospitals generating at least ____ of their revenues in the outpatient setting, based on BCBSM business, will be paid a ____ over cost until the outpatient efficiency measure is determined.

6. Margin levels will be updated only at the time of recalibration. The need for recalibration will be assessed every three years.

E. Inpatient Payment

1. Peer Groups 1-4 hospitals will be paid on a diagnosis related groups (DRG) basis using Medicare's DRG system. Changes to the classification system enacted by Medicare will be implemented by BCBSM to coincide with the effective date of changes. DRG weights will be reviewed annually and adjusted as necessary. The DRG price will be comprised of items listed in Sections 3 and 4.

2. DRG assignment will be based on the date of admission.

3. DRG weights and rates will be analyzed every three years and if necessary recalibrated (Exhibit B, Section III, H).

4. DRG Price Components:

   a. Inpatient DRG Operating Prices. Inpatient DRG operating prices will be calculated on a hospital-specific basis using each hospital's cost defined in Section III, C of this Exhibit.

   b. Capital. There will be a one-time recalibration of each hospital's capital costs effective with the implementation of the Model Reimbursement Methodology. Thereafter, capital costs will be adjusted by an annual capital update factor.

c. Graduate Medical Education. Direct Medical Education costs for hospitals with teaching programs will be reimbursed a fixed price per admission.

d. Bad Debt. On an annual basis, the most recently submitted cost report hospital-specific bad debt costs will be used to calculate BCBSM prorated share and then converted to a per-admission add-on.

e. Charity Care. On an annual basis, the most recently submitted cost report hospital-specific charity care costs will be used to calculate BCBSM prorated share and then converted to a per admission add-on.

f. Lesser of Cover Charges or DRG Payment. Per claim payments shall be limited to the lesser of covered charges or Hospital's DRG payment. Hospital's prices will include a prospectively determined hospital-specific add-on to offset the reduced payment amount. The amount of this add-on will be adjusted annually or as necessary.

g. Catastrophic Payments. A case is defined as catastrophic if its calculated cost exceeds the DRG payment amount by at least ____. Payment for catastrophic cases will be ____ of the excess cost. The cost is determined by applying the hospital-specific cost-to-charge ratio (from the Medicare cost report) to covered charges. Catastrophic cases will be subject to review and recovery of overpayments.

h. Pay for Performance. Hospitals in Peer Groups 1-4 will have the opportunity to earn additional payments of up to ____ of their inpatient and outpatient operating payment in the first year of the new Hospital Reimbursement Model, up to ____ in the second year, and up to ____ in the third year and thereafter. (Exhibit B, Section III, G).

i. Transfer and Discharge Against Medical Advice (AMA) Cases. Payment for qualified transfer and AMA cases will be an all inclusive DRG per diem (except for those DRGs that assume transfer) to the transferring hospital (not to exceed the full DRG rate) and full DRG payment to the receiving hospital.

j. Readmissions. All readmissions to the same or different hospital within 14 days should be reviewed by the admitting hospital. Where appropriate, readmissions will be combined and reimbursed a single DRG plus any applicable catastrophic case payments.

F. Outpatient Payment

1. Community-Priced Services. Community pricing is based on the premise that payment for services provided in a hospital or non-hospital setting should be the same. Community priced services will be paid as follows:

a. Laboratory Services. Laboratory services will be paid at freestanding provider levels not to exceed covered charges on a per-claim basis. Additional payment will be made for GME, uncompensated care and margin.

b. Radiology Services. Radiology services will be paid at freestanding provider levels not to exceed covered charges on a per-claim basis. Additional payment will be made for GME, uncompensated care and margin.

c. Outpatient Surgeries. Facility designated outpatient surgeries will be paid at freestanding ambulatory surgery facilities (ASFs) base fee level not to exceed covered charges on a per-claim basis. Additional payment will be made for GME, uncompensated care and margin. A site of care differential will be added for selected procedures designated by BCBSM as exclusively hospital based.

Office-based designated procedures will be paid based on the practice expense component of the Medicare Resource Based Relative Valued Scale (RBRVS) Relative Value Units (RVU) and the BCBSM professional fee screen conversion factor. Additional payment will be made for GME uncompensated care and a margin.

d. Physical, Occupational and Speech Therapy (PT/OT/ST). PT/OT/ST services will be paid at freestanding provider levels. Additional payment will be made for uncompensated care and margin.

Uncompensated care for Community-Priced services will be updated on an annual basis based on the same cost-report information as inpatient.

In accordance with the Model Reimbursement Methodology, a component for capital cost may also be included in payment rates for Community-Priced Services.

As part of P4P, hospitals will have the opportunity to earn additional payments of up to ____ of their outpatient operating payment in the first year of the new Hospital Reimbursement Model, up to ____ in the second year, and up to ____ in the third year and thereafter.

2. Other Outpatient Services. Until such time as cost-based services are community priced, payment will be based on a prospectively determined hospital specific outpatient payment-to-charge ratio set at a level to include the applicable hospital margin. Cost-based outpatient services that will be transitioned to community prices over time include but are not limited to: independent IV therapy, diagnostic and therapeutic cardiovascular services, neurological and neuro-muscular services, urgent care, chemo and radiation therapies, injectables and specialty drugs. Where applicable, additional payment will be made for GME, uncompensated care and margin.

   Other outpatient cost-based services that are not routinely available through freestanding community providers will be transitioned to fixed statewide base prices using detailed claims information reported by hospitals in accordance with guidelines established by BCBSM. These services include but are not limited to emergency care and observation beds. Where applicable, additional payment will be made for capital, GME, uncompensated care and margin.

3. Non-Acute Services. Other Hospital-based non-acute services such as, but not limited to, residential substance abuse, home health agencies and skilled nursing facilities will be reimbursed using the hospital beginning date of this Model Reimbursement Methodology; adjusted to a fiscal year beginning on or after July 1, 2006, ratio and thereafter updated by comparing, on a cumulative basis, the hospital-specific charge increases to the approved annual update factor. These services do not qualify for a margin allowance but will be updated annually consistent with other outpatient cost based services. BCBSM retains its right to change the payment methodology for each non-acute service as long as hospital overhead is appropriately allocated. If BCBSM elects to require that these services be considered as "freestanding" and subject to a separate agreement with BCBSM pursuant to BCBSM's applicable freestanding facility programs, Hospital will be granted participation status as a freestanding entity and will be given a reasonable amount of time to comply with such standards.

G. Pay-For-Performance Program

1. Hospitals in Peer Groups 1 through 4 will be eligible to participate in the Pay-for-Performance (P4P) Program.

   a. Each hospital will earn a P4P payment based on its performance on several components, including quality, efficiency and participation in selected programs. Additional components may be added over time.

   b. Specific program components, weights and performance thresholds will be determined by BCBSM on an annual basis, with input from hospitals through the PHA Contract Administration Process.

   c. The P4P payment rate for a hospital whose reimbursement arrangement complies with the Model Reimbursement Methodology will be determined by applying its total P4P score to ____. The resulting P4P rate will be applied to the hospital's combined inpatient and outpatient operating payment rate.

   d. The P4P payment rate for a hospital whose reimbursement arrangement does not comply with the Model Reimbursement Methodology will be determined by applying its total P4P score to ____. The resulting P4P rate will be applied to the hospital's inpatient operating payment rate only.

H. System Assessment and Recalibration

Every three years BCBSM will assess hospitals' reimbursement and cost levels to determine whether pricing adjustments are warranted. The decision to recalibrate will be based on a two-step sequential assessment process comprised of: (a) a system-wide assessment and (b) hospital specific assessment.

1. System-Wide Assessment. A system-wide assessment will be conducted comparing the change in the average hospital standardized cost per case over the preceding three year period with the aggregate compounded PHA inpatient update factor over the same period. BCBSM action resulting from this assessment will depend on the degree to which standardized cost per case varies from the aggregate update factor. The table below shows the relationship between the degrees of change and potential action:

Degree of Change	Action Options
< change (threshold)	No action
____change	Adjust update factor (+ or -) over three-year period *(degree of change less threshold/3)*
____change	Consider recalibration on hospital-specific basis

2. Hospital-Specific Assessment. If the system-wide assessment indicates a need for hospital-specific recalibration, the same system measures will be used to assess the need for individual-hospital recalibration. No action will be taken if the degree of change for a hospital is less than ____. Changes of ____ or higher will require recalibration of the hospital's full-cost model. GME will be excluded from recalibration but capital may be recalibrated (up to a level equivalent to the industry average) if hospital's capital cost as a percentage of total hospital costs in the previous base year was at least ____ below industry average or if their capital expenditures significantly contributed to reduced operating costs and the reduction in operating costs exceed the increase in capital costs.

Hospital-specific recalibration that will result in a decrease in a hospital's reimbursement rate will not proceed if a hospital's most recently calculated margin is ____ or less. Recalibration that would increase a hospital's reimbursement rate will not proceed if its operating margin on its most recent year audited financial statement is at least____ .

IV. Market-Based Services

Effective January 1, 2009, Peer Groups 1-4 hospitals' outpatient payment for community-priced services and other outpatient services that are designated market-based services will change to market-based rates. If any provision of this Section IV conflicts with other Exhibit B Sections, the provisions of this Section IV shall prevail. For the initial implementation, Market-based services include outpatient laboratory, radiology, and surgery. Market-based pricing refers to the payment level for a market-based service to a hospital being equivalent to the level of payment a non-hospital provider receives from BCBSM.

A. Reimbursement Principles

Upon implementation, Peer Groups 1-4 hospitals inpatient and outpatient reimbursement rates will be based on the following principles:

1. Market-based service reimbursement, on a hospital-specific basis, will be modeled and implemented in a manner projected to be "budget neutral". The budget neutral analysis will be afforded to all hospitals for whom market-based pricing is effective on January 1, 2009, and will be based on prices that would have been effective January 1, 2009, in the absence of this initiative, and on hospital utilization information related to fiscal years ending from January 1, 2007, through December 31, 2007.

2. All prices and price components of hospitals' inpatient and outpatient payment rates determined under this Exhibit B, and in effect prior to implementation, will be adjusted. Inpatient and outpatient payment rates determined under a specific contract amendment whose term extends past the effective date of market-based service implementation will also be adjusted upon mutual written consent of Hospital and BCBSM.

3. Prices and price components include, but are not limited to, DRG operating price, capital price, graduate medical education price, uncompensated care price, pay-for-performance incentive, passthrough factors, and the outpatient payment-to-charge ratio.

4. There will be a one-time recalibration of each hospital's inpatient and outpatient payment rates to accommodate the initial implementation of market-based pricing. The recalibrated payment rates will supersede the rates immediately in effect prior to implementation. Thereafter, the established inpatient and outpatient payment rates will be adjusted in accordance with this Exhibit B. In the event other services are designated market-based after January 1, 2009, the implementation of market-based pricing for such services will occur in a similar manner as stated in this Section IV.

B. Implementation

1. In the year of adoption, and on a hospital-specific basis, implementation of market-based pricing will be made in a budget-neutral manner as described above. Payment amounts removed from market-based services will be reallocated to inpatient and emergency services. Budget-neutral implementation will assume the base-year cost used to set hospital reimbursement rates was incurred in a reasonably efficient manner. There is no guarantee of perpetual budget neutrality in subsequent years; however, the established prices will be the basis for subsequent year updates. That is, the market-based payments amounts reallocated to inpatient and outpatient services will be adjusted annually by the standard PHA update. Upon rebasing, these amounts will be limited to the lower of the updated amount or rebased cost. Implementation of market-based pricing will occur as follows:

   a. The portion of hospitals' reimbursement associated with market-based services that is above the applicable base fee-screen level will be allocated to hospital-based services.

   b. The amount identified in subsection a, above, will be allocated to inpatient services. BCBSM and Hospital may jointly agree to allocate a portion to outpatient emergency service reimbursement rates. In some cases, BCBSM and Hospital may jointly agree to allow for the continuation of a small passthrough factor for market-based services.

   c. The amount will be allocated to the following comparable components of inpatient services:

      i. Capital – This component will have the capital update factor applied and will be limited to the inflated per-admission amount at the time of any rebasing. (1)

      ii. Graduate Medical Education – This component will have the graduate medical education update factor applied and will be

limited to the inflated per-admission amount at the time of any rebasing. (1)

iii. Uncompensated Care – This component will continue to be subject to the uncompensated care passthrough process and will be updated each year following the existing uncompensated care update process.

iv. Other – This component will have the standard inflation factor applied and will be limited to the inflated per admission amount at the time of any rebasing. (1)

d. The amount allocated to emergency services will be tracked as a single add-on component to the emergency percent-of-charge reimbursement ratio. This add-on will be subject to the standard annual update process, and the amount of the add-on will be limited to the original add-on amount, including applicable updates, at the time of any rebasing. (1)

e. Other considerations

i. Lab Screens - BCBSM hospital lab fees will be set at BCBSM PLUS Lab rates prior to the market-based pricing allocation or the cost allocation process taking place. The difference between current BCBSM hospital lab payments and BCBSM PLUS Lab reimbursement will be built into the costs reallocated to hospital-based services.

ii. In the event payment for emergency services become price-based, the add-on will be converted to a passthrough factor component. The add-on component of the emergency room passthrough factor will be tracked separately and will be limited to the original add-on amount, including applicable updates, at the time of any rebasing. (1)

2. Pay-for-Performance – Pay-for-performance payments will continue to be worth up to ____ of inpatient and outpatient operating payments for Model hospitals and up to a maximum of ____ of inpatient operating payments (prior to any market-based related allocation from outpatient) for non-Model hospitals.

3. In subsequent years, the continued use of the "full-cost" hospital reimbursement model for market-based services is not guaranteed nor perpetual. Once budget-neutral implementation occurs, hospital costs that are directly linked to, or are allocated to, market-based services will not be guaranteed during future rebasings. (1) Instead, the amount allocated from market-based services to hospital-based services will be tracked and

updated annually, including during the rebasing exercise, based on the applicable update factor and process.

(1) The rebasing and recalibration process that utilizes FYE between June 2007 and March 2008 as the base year will proceed as follows:

- BCBSM will forego the industry wide rebasing assessment and instead apply a hospital specific rebasing assessment.
  - BCBSM will consider using an adjusted cost per equivalent admission measure rather than the standardized inpatient cost per case for the comparison to the cumulative BCBSM update factor. This comparison will be used to determine if subsequent years' updates will be adjusted up or down, or whether a full rebasing will be considered.
  - If a rebasing is applicable for an individual hospital, all operating prices, including the inpatient add-ons (the add-ons associated with redoing the market based implementation steps) will be rebased. The inpatient add-ons are subject to the full rebasing process only at the time of the next rebasing. Subsequent rebasings will apply to the inpatient add-ons as described in the foot noted section, above.
- A full rebasing on capital would be allowed. The analysis will include the calculation of a statewide average capital cost measure (capital expense as a percent of total hospital operating expense). Hospitals below or equal to the average will be allowed an annual update on capital related price components. Hospitals above the average will not have an annual update applied. However, in subsequent rebasings, the statewide measure will be recalculated and capital price components may be resynched for hospitals that were previously over the limit. For example, hospitals over the average will be allowed to have their capital rebased to the extent that their rebased operating expenses have decreased. .
- All GME costs will be subject to a full rebasing.
- Uncompensated care for both inpatient and outpatient prices will continue to be updated annually based on the actual cost. Payment will not be a pass-through subject to settlement, but will instead continue to be a prospectively determined component of hospital reimbursement rate. However, the lag time will be shortened to two years from the previous three.

V. Annual Update Process

Hospitals whose reimbursement arrangement complies with the Model Reimbursement Methodology will have their inpatient rates, outpatient and capital prices updated as follows:

A. Inpatient Rates.

1. Inpatient reimbursement rates will be updated annually. The inpatient update factor will be determined by the following two factors:

a. The applicable fourth quarter projection of the National Hospital Input Price Index (NHIPI), as reported by Global Insight in its third quarter report prior to the effective date of the update factor.

b. An adjustment to the NHIPI that is equal to the lesser of the following:

i. The change between the initial NHIPI projection and the currently reported NHIPI, for the calendar year that is two years prior to the effective date of the update factor.

ii. ____ of the current NHIPI projection, as defined in Section IV, 1.a.

2. The update factor will be determined once annually and used for all hospitals. The update factor will be applied to each hospital's inpatient reimbursement rate on its fiscal year beginning date.

3. The update factor will be applied to the hospital-specific base rate or per diem amount, GME and percent of charge payments.

4. The update factor will be calculated and communicated to hospitals each August prior to the calendar year in which it becomes effective.

B. Outpatient Price Updates.

1. Price-Based Services. Fees for all price-based services, including laboratory and radiology services, surgeries, physical, occupational and speech therapy and all other priced-based services, will be updated based on BCBSM's professional (physician) fee updates or other update factors that may be appropriate to reflect market rates

2. Cost-Based Services. On an annual basis, hospital-specific charge increases for cost-based services will be compared to the established inpatient update. The hospital-specific payment-to-charge ratio in effect for the fiscal year ending prior to the beginning date of this Model Reimbursement Methodology is the base ratio. This ratio will be adjusted to a fiscal year beginning on or after July 1, 2006, ratio. Thereafter, it will be updated by comparing, on a cumulative basis, the hospital-specific charge increases to the approved annual update factor, with the update limited to the same BCBSM annual update factor as established for inpatient prices.

C. Capital Prices.

1. Updates to capital prices will be determined using the New Vintage Weighted Forecast supplied by Global Insight.

2. The capital update factor will be determined once annually and used for all hospitals. The capital update factor will be applied to each hospital's capital payment on its fiscal year beginning date.

3. The capital update factor will be calculated and communicated to hospitals each August prior to the calendar year in which it becomes effective.

V. Peer Group 5 Hospitals

A. Reimbursement Principles

Peer Group 5 (PG 5) hospitals' inpatient and outpatient reimbursement rates and the reimbursement policies that guide the development of these rates will be based on the following principles:

1. Reimbursement rates will be set at a level that equates to ____ over efficiently incurred generally accepted accounting principles (GAAP) hospital costs.

2. Due to the smaller size and other unique characteristics of PG 5 hospitals, a provision will be made whereby BCBSM will help to cover a share of the costs associated with the under funding by governmental programs.

3. BCBSM will compensate PG 5 hospitals for a share of the cost of uncompensated care (bad debt and charity).

4. A Pay-for-Performance (P4P) program will be developed specific to PG 5 hospitals. PG 5 hospitals must meet the established measures to gain the full level of reimbursement encompassed by the principles outlined above.

5. Hospitals will be required to provide information necessary to determine appropriate reimbursement rates consistent with these principles. BCBSM will share the results of all analyses related to the determination of hospitals' reimbursement rates.

6. Except as noted below, PG 5 hospitals will be reimbursed on a percent of covered charges basis. Under no circumstances will payments exceed covered charges.

B. Foundational Payment Model

The following payment model is the basis for the BCBSM Peer Group 5 hospital Model Reimbursement Methodology (MRM).

This is an illustration of the payment model only, given that many components are hospital specific.

Category	Amount
Full GAAP cost (net of bad debt) (1)	
Margin	
Uncompensated Care (2)	
Governmental shortfall (2)	
Uncompensated Care gross-up (2)	
Governmental payor gross-up (2)	
P4P (3)	
Sub Total	
Other operating income offset (2)	
Total (4)	

(1) Full GAAP is determined by applying the overall hospital cost-to-charge ratio to BCBSM/BCN charges. Hospital and other hospital-based services (such as SNF) that are reimbursed under the PG 5 reimbursement model are to be included in the analysis. In addition, in certain PG 5 areas, where it is necessary for the hospital to employ or otherwise financially support physicians to ensure adequate access, physician costs may be allowed in full GAAP costs. Where physician-related costs are allowed, physician-related revenue will be included in the other operating revenue offset. Section J provides additional definition related to physician expense.

(2) Hospital-specific measure. Shortfalls and gross-ups are defined in Section K. Hospitals will be required to provide necessary information, in a timely manner, to determine the appropriate shortfalls and gross-ups.

(3) The hospital-specific governmental shortfall and gross-up, in total, have been reduced by ____ to fund the ____ P4P program.

(4) Individual hospital rates may vary above or below ____ based on hospital-specific data.

C. Model Reimbursement Methodology Analysis and Implementation

The base year used for the analysis will be a hospital's FYE on or before March 31, 2007. The analysis will be completed every three years. Transition to the MRM begins with fiscal year beginning on or after 7/1/2007.

1. If the application of the MRM results in a ***decrease*** in reimbursement rates, then one of the following provisions will apply.

   a. If the MRM yields a decrease greater than ten points and the hospital's most recent AFS shows an operating margin of at least ____, the decrease will be phased in over a three year period.

   b. If the MRM yields a decrease of less than or equal to____, or a decrease greater than ____ but with an operating margin less than ____, the hospital's rates will be frozen until application of the standard annual

update process brings the hospital's rates in line with the MRM. However, a freeze will only be allowed if the hospital is in compliance with the Most Favored Discount provision of this Section.

2. If the application of the MRM results in an ***increase*** in reimbursement rates, then the following will be applied.

   a. Reimbursement increases will only be considered if the hospital operating margin is less than ____ , and

   b. Increases will only be allowed if the hospital is in compliance with the Most Favored Discount provision of this Section.

   c. Increases will be phased in over an extended period of time such that the allowable increase in any year is not greater than____ higher than the standard annual update amount.

3. If the operating margin from the most recently available Audited Financial Statements is greater than ____ then, regardless of the results of the MRM, rates will be decreased to a level no greater than ____ of full GAAP cost, subject to the following.

   a. If the hospital is in compliance with the Most Favored Discount provision of this Section, the maximum decrease in a single year will be____ . If a greater discount is afforded to another private payor, a minimum decrease of ____ will be applied, and

   b. The decrease will be limited to the extent that the change will not bring the hospital operating margin below the ____ level.

D. Other Implementation considerations and restrictions

1. PG 5 Hospital Risk Factor - BCBSM will consider a low volume adjuster if a hospital's utilization decreases by over ____ in any given year. The trigger for the utilization decrease would be measured by Equivalent Inpatient Admissions (EIPAs). For example, this would translate to a decrease of ____ assuming ____ in the base year. Meeting this threshold would result in a corrective payment adjustment being added to the subsequent years' rates to assure adherence to the MRM principles. Payments will not be retroactive. This additional payment adjustment will be made only if the hospital is in compliance with the Most Favored Discount provision of this Section and the hospital operating margin is less than____ . Decreases in EIPAs related to the discontinuation of a service will not be included in the calculation.

2. Hospitals that move from PG 5 to non-PG 5 or, non-PG 5 to PG 5 status will be transitioned over a three-year period except where a different transition period is specified elsewhere in this Section. Review of hospital status will

include a three-year average and overall trend to ensure the potential status change is reflective of a continuing trend and not the result of a one-year fluctuation. Hospitals that move from PG 4 to PG 5 will continue billing under DRG and fee screen instructions. Payment rates will be adjusted to emulate the PG 5 MRM.

3. Any outpatient services provided at a location that is closer to a PG 1-4 hospital than it is to the PG 5 hospital's main campus will be reimbursed based on fee screens and the average PG 4 passthrough factor. Outpatient services that are not fee screen reimbursed will be reimbursed at a payment-to-charge ratio based on the average of PG 4 hospitals. Outpatient locations in operation on June 30, 2007 may be grandfathered at existing controlled charge or MRM rates, depending on the service and relationship to PG 5 MRM principles. BCBSM will require a list of all such locations. BCBSM's decision to grandfather the services offered at a particular location will be made based on the overall purpose and necessity of the services at the time it became operational. If BCBSM determines the overall purpose was to meet a community need, it may be grandfathered. If BCBSM determines the effect was to encroach on a PG 1-4 service area, which results in higher payments for such services, then the location will not be grandfathered.

4. High-tech imaging services, currently defined as CT, MR, and PET procedures will be paid at controlled charges only if a high compliance rate with BCBSM utilization management programs is maintained. Controlled charge reimbursement will only be allowed if compliance with BCBSM Utilization Management programs is in the ____ quartile of PG 1-5 hospitals, or achieved a compliance rate of ____, whichever is lower. Any changes in the definition of high-tech imaging services are subject to the input of the PHA Advisory Committee. The first measurement period for which hospitals will be expected to attain top-quartile performance will be no sooner than the first six month period beginning on July 1, 2007.

5. PG 5 hospital rates will be rebased every three years to include changes in Medicare and Medicaid shortfalls as well as cost changes. Hospitals may be rebased immediately if there is a change in their "critical access hospital" designation by Medicare, or if there is a change in the reimbursement methodology for critical access hospitals.

6. Hospitals with annual BCBSM/BCN payments less than ____ may be exempt from the MRM as long as they are in compliance with the Most Favored Discount provision of this Section. The____ level is based on 2006 BCBSM/BCN reimbursement and will be indexed annually based on the BCBSM annual update factor process.

E. Pay for Performance

The P4P program puts part of a hospital's total reimbursement at risk. The P4P pool is funded by carving ____ off of the hospital specific governmental shortfall and gross-up components. The entire P4P payment will be automatic for all hospitals in the first year of the new MRM. ____ will be at risk in year 2, ____ points in year 3, and all ____ beginning in year 4. The P4P program will be developed in a collaborative manner with input from hospitals and will be specific to PG 5 hospitals. The programs will not be cost prohibitive but will provide validation that hospitals have appropriate quality and efficiency programs in place.

A PG 5 technical advisory group (TAG) will be created to provide ideas and input. BCBSM and the TAG will work toward consensus on meaningful quality and efficiency measures and processes. BCBSM agrees to seek approval by the PHAAC prior to implementation. If the timetable for implementing the program is at risk, then BCBSM will make the final decision while maintaining its commitment to the highest degree of collaboration possible.

F. Most Favored Discount

Hospital will attest and commit that the payment rates which it has provided to BCBSM under this Agreement for non-Medicare members are at least as favorable as the rates which it has established with all other non-governmental PPOs, non-governmental HMOs or other non-governmental commercial insurers. On an annual basis, an officer of the Hospital, together with the Hospital's CPA will provide an attestation that the payment rate given BCBSM meets the terms of this provision. If such attestation from the Hospital's CPA proves to be prohibitively expensive, an alternative approach may be considered. Should BCBSM determine that there is a potential violation of this provision, it may engage an independent third-party auditor to review and audit Hospital's financial records to ascertain whether there has actually been a violation. If a violation of this Section has occurred, BCBSM reserves the right to recover the amount of excess reimbursement as well as to immediately adjust Hospital's reimbursement rates to mitigate continued overpayments.

This Section shall become effective no later than Hospital's fiscal year which commences on or after July 1, 2009. Failure to comply with the terms of this Section will result in Hospital not being afforded the PG 5 MRM, but instead, Hospital will only be entitled to reimbursement as a PG 4 Hospital.

Failure of Hospital to provide the attestation required pursuant to this Section will result in no increases in reimbursement rates under the PG 5 reimbursement MRM, if any such increase is warranted. Reimbursement rates will not be increased retroactively but will only apply to payments on a prospective basis.

G. Annual Update Process.

The reimbursement rate update factor for PG 5 hospitals whose reimbursement arrangement complies with the MRM will be the same as the update factor determined in accordance with the provisions of Section IV.A.1. of this Exhibit B for non-PG 5 hospitals.

H. Non-Acute Services.

Other hospital-based non-acute services such as, but not limited to, residential substance abuse, home health agencies and skilled nursing facilities will be reimbursed at the same level established for acute care. BCBSM retains its right to change the payment methodology for each non-acute service and to treat these services as "freestanding" and subject to a separate agreement with BCBSM pursuant to BCBSM's applicable freestanding facility programs. At such time, regardless of compliance with BCBSM's qualification standards for these programs, they shall be granted participation status and given a reasonable amount of time to comply with such standards.

I. Transition Hospitals.

Transition hospitals are those hospitals that move between Peer Groups 4 and 5 due to changes in total EIPAs or other measures used as PG 5 qualifying criteria. With the implementation of the MRM, initial peer group assignment relative to EIPAs will be based on the benchmark criterion of ____ and each hospitals' base-year calculation. After this initial determination, to minimize the movement of hospitals between Peer Groups 4 and 5 based on EIPAs, the benchmark level of ____ plus or minus ____, whichever direction is applicable, must be met for two consecutive years for a hospital to change peer group assignment. The following policy will apply to hospitals that become transition hospitals effective with fiscal years beginning on or after July 1, 2007:

1. A PG 5 hospital with annual EIPAs that exceed ____ in two consecutive years will be categorized as a PG 4 hospital. Changes in peer group assignment will occur at the beginning of the fiscal year immediately after the second fiscal year in which Hospital's total annual EIPAs are greater than ____ and all other PG 4 characteristics are met. The transition in reimbursement levels will be the same as defined in Section V.C.1.

2. A PG 4 hospital with annual EIPAs of fewer than ____ in two consecutive years will be categorized as a PG 5 hospital. Changes in peer group assignment will occur at the beginning of the fiscal year immediately after the second fiscal year in which Hospital's total annual EIPAs are fewer than ____ and all other PG 5 characteristics are met. The transition in reimbursement levels will be the same as defined in Section V.C.2.

A hospital that loses its rural designation as defined by the United States Census Bureau will be classified as a PG 3 hospital. Changes in peer group assignment will occur at the beginning of the fiscal year immediately after the fiscal year in

Exhibit D

APPEAL PROCESS

All references in this Exhibit to days are to calendar days.

I. Appeals of Reimbursement Policies

A. General Requirements

BCBSM shall establish and communicate to Hospital a procedure by which Hospital may obtain a timely BCBSM decision of the interpretation and application of Reimbursement Policies as applied to Hospital's specific circumstances. Prior to taking any other action, Hospital shall submit any dispute concerning the proper interpretation and application of Reimbursement Policies as applied to Hospital's specific circumstances to BCBSM for its decision.

At the conclusion of each point in the appeal process, BCBSM will forward the findings to the Hospital. At the conclusion of the appeal or at any point in the appeal process, if the Hospital agrees with or chooses not to dispute the findings, the appropriate adjustments will be finalized.

If the Hospital disagrees with BCBSM's decision rendered during the appeal process and wishes to have a specific adjustment reviewed at a higher level, the Hospital may do so by submitting a request in writing within the time frame specified for each review level in this exhibit. The request must include the following:

- Area of dispute
- Reason for disagreement
- Dollar value of appeal
- Additional documentation specific to the area of dispute and an explanation of its relevance. Hospital must make a good faith effort to submit all such documentation with its appeal
- Fiscal years covered

B. Hospital Applications

If Hospital fails to meet any of the designated time frames, its appeal will be denied. If BCBSM fails to meet any of the designated time frames, Hospital may petition BCBSM in writing for an immediate decision. If BCBSM does not render a decision on all issues involved in Hospital's appeal within ten (10) days of receiving Hospital's petition, the appeal will be decided in favor of Hospital with respect to all issues not expressed in BCBSM's opinion, if any. Hospital must enter the process at the BCBSM Management Review level and must proceed through each level of the process.

Following is the appeals process:

1. BCBSM Management Review. If the Hospital disagrees with BCBSM's decision, the Hospital may request Management Review. The written request for the Management Review along with the required documentation listed above must be submitted within ninety (90) days of receipt of BCBSM's notification with respect to the determination under appeal. BCBSM will conduct the Management Review meeting and provide a written response to the Hospital. BCBSM will acknowledge receipt of the appeal within fourteen (14) days and will render a management decision within one hundred twenty (120) days of receipt of appeal.

2. Internal Review Committee (IRC). If Hospital disagrees with the final Management Review decision, Hospital may request review by the IRC within thirty (30) days of receipt of the Management Review decision. The request for review should be submitted in writing, by certified mail, to the Director of Provider Contracting. The IRC will schedule a hearing that shall occur within one hundred twenty (120) days of receipt of the request for IRC review and will notify Hospital of its decision within thirty (30) days after the hearing.

3. Provider Relations Committee. If Hospital disagrees with the decision of the IRC, it may request review by the Provider Relations Committee (PRC) of the BCBSM board of directors. Hospital must submit its request in writing, by certified mail for PRC review within thirty (30) days of receipt of the IRC decision letter. BCBSM will schedule a hearing before the PRC which shall occur within one hundred eighty (180) days of receipt of Hospital's request for PRC review. The PRC will issue its decision within thirty (30) days after the PRC meets to consider the appeal.

II. Appeals of BCBSM Adverse Determinations

Hospital has the following appeal rights with respect to Prospective, Concurrent and Retrospective Reviews.

A. Prospective or Concurrent Reviews

BCBSM will provide an expedited appeal process for review of adverse determinations on imminent or ongoing services. If Hospital disagrees with an adverse determination on prospective or concurrent review, Hospital may request internal appeal. The Hospital must submit a written request to BCBSM within thirty (30) days of discharge. The request must include the following:

- Patient's name
- Contract number
- Dates of service
- Complete medical record
- Any additional supporting information

BCBSM will decide the appeal and report its decision to Hospital within thirty (30) days of receipt of Hospital's written request for appeal. If Hospital continues to disagree with BCBSM's determination, it may request an External Review as provided in Section C.

B. Retrospective Reviews

After the audit is complete, BBSM will notify Hospital of the audit determination in a reporting letter sent via certified mail. Hospital will have fifty (50) calendar days from receipt of the letter in which to submit a written request for internal review if it does not agree with the BCBSM determination. Hospital must submit written rationale and all supporting documentation explaining the basis for its disagreement with its request for Internal Review. The name of the attending physician must be included with the request.

Hospital's request for Internal Review, along with written rationale and all supporting documentation, must be postmarked no later than fifty (50) calendar days from its receipt of the reporting letter. BCBSM's decision will be maintained if Hospital does not submit its request, written rationale and all supporting documentation within this time frame.

BCBSM will notify Hospital of the Internal Review decision by letter postmarked no later than fifty (50) calendar days following its receipt of Hospital's request for Internal Review. Hospital's appeal will be granted if BCBSM does not respond within this time frame.

C. External Appeal

If the Hospital continues to disagree with BCBSM's determination under A. or B., the Hospital may request an External Appeal. BCBSM has no appeal rights and is bound by the decision if a Hospital chooses not to appeal.

Hospital must submit its written request for External Review within twenty (20) calendar days of receipt of BCBSM's decision. The request must include:

- Patient's name
- Contract number
- Dates of service

Neither party may submit to the external review agency any information or arguments not previously submitted to the other.

BCBSM will report the decision of the external peer review agency to Hospital within forty-five (45) days of receipt of Hospital's written request for appeal. The decision of the external peer review agency is final.

External appeals in cases involving Medical Necessity, site of care or quality of care will be reviewed by a peer review organization composed of practicing physicians. Cases involving DRG coding disagreement will be sent to an independent coding expert for a determination. (Disputes involving benefit determination are not appealable externally.)

In all cases in which the peer review agency upholds BCBSM's decision, Hospital will pay the cost of the appeal.